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LEARNING ABOUT CHILDBIRTH: A CULTURAL TRANSMISSION STUDY AMONG NULLIPAROUS WOMEN

BY

LAURIE McCREARY-BURKE ©

A Thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements for the degree of Master of Arts

DEPARTMENT OF ANTHROPOLOGY

EDMONTON, ALBERTA
SPRING 1995

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled LEARNING ABOUT CHILDBIRTH: A CULTURAL TRANSMISSION STUDY AMONG NULLIPAROUS WOMEN submitted by LAURIE McCREARY-BURKE in partial fulfilment of the requirements for the degree of MASTER OF ARTS.

Dr. Pamela Brink, Supervisor

Dr. Tony Fisher

Dr. Peggy-Anne Field

DATE: 26 January 1995

DEDICATION

To John, Caitlin and Jay

ABSTRACT

The purpose of this study was to explore and describe the process of the cultural transmission of childbirth knowledge among nulliparous women. Semi-structured interviews were used to elicit data from women in the early, middle and late stages of their first pregnancies. The data were analyzed to discover common themes with regard to the circumstances surrounding the cultural transmission of childbirth knowledge. This included the analyses of the social settings in which knowledge was transmitted, the age of the participants at the time of transmissions, the relationship of the transmitters to the learner, and the learners' assessment of the credibility of discrete transmissions. Formal prenatal education is therefore examined as one of the many forms of cultural transmission and is evaluated in relation to the entire scope of childbirth knowledge. The results of this study suggested that in the period prior to pregnancy women develop detailed concepts and expectations of childbirth which in many respects restricts what is learned post-pregnancy.

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CHAPTER I - INTRODUCTION

Childbirth, a universal biological event, is everywhere mediated by culture (Mead and Newton, 1967; Jordan, 1993; Kay, 1982; Spencer, 1986; Ginsburg & Rapp, 1991; Callaway, 1992). In all cultures, not only are the roles and statuses of various birth attendants culturally ascribed, but also the birth setting and birth technologies (tools, substances, surgeries, and physical manipulations), the prescriptions and proscriptions concerning food and activities of childbearing women and their families, and the rules designating those members of society who are permitted to have access to, and knowledge of birth. This complex set of ascribed childbirth knowledge has an element of "moral requiredness" (Jordan, 1993:122); the childbirth practices classified as appropriate in one culture may be classified as inappropriate (if not abhorrent) in others.

As is the case with all knowledge, knowledge of culturally appropriate childbirth practice is perpetuated through the process of cultural transmission. This process is governed by a set of rules for transmitting childbirth knowledge to the appropriate categories of individuals at the appropriate time (see Morse, 1989 for examples of cultural transmission among two Fijian populations), and through this process all social members involved with birth come to "know" the "cultural script" (Pitman, et al., 1989) for "doing birth" (Jordan, 1993). The cultural script encompasses sets of generalized knowledge which define the concepts of pregnancy, birth and the postpartum period, as well as who does what (to whom) when, where, how, and why (participants, relationships, activities, tools, setting, and values). The cultural script further includes sets of specialized technical knowledge which the various designated birth participants are expected to apply to the accomplishment of their own role in the birth process. Prior to giving birth, an uninitiated woman's

childbirth knowledge consists solely of some portion of the knowledge contained within the cultural script; she does not yet have experiential knowledge of childbirth. The visceral knowledge a woman acquires through the physical act of giving birth will be interpreted within the cultural script she already knows. In other words, it is the cultural transmission of childbirth knowledge which provides women with a framework for interpreting their physical and emotional experience of giving birth.

In Canadian society (and many other Western societies) culturally ascribed childbirth knowledge and practice have been in transition throughout the twentieth century (Cayley & Mason, 1985; Walzer Leavitt, 1987 & 1988; Sandelowski, 1984; Arney, 1982). The reclassification of the concept 'childbirth' from a non-medical to a medical category originated in the seventeenth century and reached completion during the last half of the twentieth century (Arney, 1982). The availability of alluring new technologies which promised to ameliorate women's pain in labour and which promised to produce safe outcomes resulted in gradual public acceptance of medical hegemony over childbirth practice and attested to the cultural belief in, and enthusiasm for, scientific knowledge and technologies (an emblem of progress and of human control over nature) (Beinart, 1990; Sandelowski, 1984). Safety and pain control were consequently established as the primary moral requirements for judging and justifying what constitutes appropriate childbirth practice and the responsibility for achieving these moral goals was socially delegated to specialized medical professionals who were deemed the only members of society who had the competence and the technological skills and tools to properly supervise and assist at birth. With few exceptions, birth now occurs in isolation from the normal round of daily activities in hierarchically organized hospital settings.

The restructuring of childbirth practice, however, has been both problematic and controversial. A fierce debate has raged for most of the century and has produced further refinements in the cultural ascriptions of what constitutes appropriate childbirth practice in modern society. At the heart of the debate lies the issue of whether better outcomes (safety) are achieved when nature is allowed to take its course or whether technology can be efficaciously used to intervene when nature appears to have gone awry (Tew, 1990; Dick-Read, 1953:154; Karmel, 1965:33; Bradley, 1974:14-20). This debate (discussed in more detail in Chapter V) is deceptive for although "natural childbirth" is held up as the ideal, childbirth practice is oriented toward management, prediction, control and intervention. This orientation implies a belief in human ability to know what nature is likely to do, and it therefore requires the definition and delimitation of the natural course of pregnancy and childbirth (Arney, 1982:52-85). But by whom is it defined and what criteria are used in the definition? Who is the final arbiter when there are disagreements over the definition? Is it the woman on whose body the intervention is performed? Is it the childbirth practitioner? Is it the judge and jury in a courtroom? (Gorovitz, 1983). The debate, therefore, although cast in the terms of nature versus technology, is in reality a debate over the meaning of "natural" and the identification of the appropriate use of technology.

Questions concerning the safety and appropriate use of childbirth interventions have long been debated in medical journals and texts, but publication and dissemination of medical research has not always had an immediate, direct affect on either the perpetuation or strict limitation of the use of various interventions (Arney, 1982; Hahn, 1987; Dick-Read, 1953:113-116). At least in theory, the publication of research should act as a mechanism for self-policing within the ranks of the medical profession. As British obstetrician

Grantly Dick-Read pointed out, however, it was difficult for medical professionals to police themselves when faced with the moral and compassionate obligation to comply with their patients' demands for interventions, particularly the demand for pain medication (Dick-Read, 1953:112). Dick-Read's proposed resolution to the problem was to introduce childbirth education programs as a means of curbing women's need for pain medication and attendant interventions.

According to Dick-Read, childbirth education programs could be used to re-educate women and to counter the misinformation (culturally transmitted) which created women's fear of childbirth. Dick-Read theorized that fear caused excessive muscular tension which exacerbated pain and created the need for (dangerous) pain medication. Reducing women's fear of childbirth could be achieved by educating them about the physiological aspects of birth (i.e. the medical definition of childbirth) and teaching them "natural" relaxation techniques. The reduction of fear and promotion of relaxation would hence reduce tension, pain and the need for pain medication. The resultant "natural childbirth" technique promised to fulfil the culturally ascribed moral goals by safely ameliorating women's pain.

Although a variety of childbirth education methods have been conceived and promoted (including the Dick-Read, the Lamaze and the Bradley methods), all forms of childbirth education have placed the onus for curbing the demand for intervention and achieving 'natural childbirth' squarely on the shoulders of the 'consumer' of childbirth services, while at the same time upholding the physician's supervisory responsibility over birth (Beinart, 1990:128; Dick-Read, 1953; Karmel, 1965; Bradley, 1974). Indeed, the advent of prenatal education has contributed heavily to the creation of the modern childbirth 'consumer' and the creation of organized 'consumer' groups.[1] In fulfilling her role in the cultural script, the 'consumer' is expected to learn about childbirth

so that she may choose from (or demand) a menu of options. She is expected to evaluate the risks and the benefits of those options in consultation with her (carefully selected) childbirth practitioner. She is ultimately vested with the responsibility for giving her (informed) consent to all procedures performed during pregnancy, labour and birth. The defining characteristics of the 'consumer,' therefore, are that she is (or becomes) knowledgeable about childbirth options and that through her acquisition of childbirth knowledge she is enabled to wield the 'consumer' power she requires to enlist the co-operation of her birth attendants.

There can be little doubt that the exercise of 'consumer' power has had a profound affect on the definition of appropriate childbirth practice. Since the introduction of prenatal education programs, 'consumers' have fought for and been accorded the right to have their husbands and other significant others attend birth. The physical space of the birth setting has been refashioned and redecorated to imitate the home environment. Women are no longer routinely transferred from the labour room to the delivery room, but rather birthing rooms equipped with birthing beds allow for more continuity in the process of labour and birth. Former routine obstetrical practices such as preparatory perineal shaves and enemas occur less frequently now than they did in the past.

Despite these changes, childbirth education appears to have had little effect on the use of many interventions. On the contrary, during the period in which childbirth education became widely popularized (1970's and 1980's), the caesarean section rate in Canada increased from 5.2% in 1969 to 18.7% in 1987 (Milne, 1991:6). That is to say, that although a higher percentage of women were trained in "natural childbirth" techniques, a higher percentage experienced the ultimate intervention of caesarean section. There is no suggestion here that a simple one to one relationship exists between childbirth education and the ascending caesarean rate.

The situation is much more complex than that. Nevertheless, when one considers that intervention in childbirth continues unabated despite childbirth education programs, it is appropriate to question the role women's childbirth knowledge plays in the definition of appropriate childbirth practice.

Statement of the Problem and Research Question

Culturally appropriate childbirth practice is constructed through the interaction of (at least) three levels of social discourse: the level of health care professionals, the level of public debate, and the level of recipients of maternity care services. On the first level, health care professionals "own" and produce technical biomedical knowledge, and use this knowledge to organize their behaviour in relation to childbearing women. Knowledge is a powerful entity, particularly knowledge claimed by a group of professionals (Duden, 1991; Holzner & Marx, 1979; Illich, 1976). The professionals' claim to knowledge invests them with authority in a particular realm, and because professionals use specialized language and concepts, members of society have no direct access to professional knowledge. Such claims of specialized knowledge allow professionals to define and categorize all aspects of the realm, including what they consider to be "normal" and "abnormal." Professionals could not, however, successfully sustain their authority unless their claim of specialized knowledge were accepted by society. In regard to childbirth, physicians make a claim to "know" more about the subject than the rest of society, and society has granted them the authority to apply this knowledge to childbirth (Irwin & Jordan, 1987).

On another level of social discourse, the merits of various childbirth practises are publicly debated via the media of newspapers, magazines, television and books. Unlike the level of 'medical knowledge,' this level of knowledge is directly accessible to members of society. Those intent on

reforming childbirth practice use this level of social discourse to critique the use of routine medical interventions and concomitantly, those intent on maintaining childbirth practice use this level of discourse to interpret and endorse medical procedures and medical innovations to the public. Presumably the debate on this level of discourse would not exist if there were general agreement about what constitutes appropriate practice. But more importantly, because this level of discourse intervenes between 'medical knowledge' and the knowledge held by the individual, it plays an important role in the definition of appropriate childbirth practice. Indeed, the success of the childbirth 'consumer' movement can largely be attributed to the public debate that takes place on this level of social discourse.

Either the maintenance or the transformation of childbirth practice appears to require more than merely public debate, however. As Robert Bradley (1974) noted in his monograph Husband Coached Childbirth, when hospital authorities refused to admit husbands to the birth chamber, expectant fathers hand-cuffed themselves to their wives' labour beds. This action had a profound affect on the transformation of childbirth practice, and suggests that individual acts have played an important role in redefining childbirth practice. This also indicates that numerous individuals were unwilling to concede to health care professionals the sole prerogative to define appropriate childbirth practice.

On the third level of social discourse, one must therefore consider the extent to which women's childbirth knowledge (and their interactions with health care professionals based on that knowledge) affects the definition of appropriate childbirth practice. On the one hand, 'consumers' have played an important role in reforming childbirth practice and on the other hand, routine medical interventions continue to be used despite the efforts of prenatal educators to promote "natural childbirth." If childbirth practice is being thus maintained,

we must question whether women's childbirth knowledge plays an equally important role in maintaining practice as it does in affecting change. Does the childbirth knowledge women acquire (including the definition and delimitation of "natural" or normal childbirth) empower them to challenge medical authority or does this knowledge increase their acceptance of intervention? Indeed, it is impossible to know what role women's childbirth knowledge may play in the definition of appropriate childbirth practice unless there is clear evidence to indicate what it is that women know about childbirth.

What do women, particularly women who are expecting their first child, know about childbirth? Under what circumstances is this knowledge culturally transmitted? What influence do various sources of childbirth knowledge have in shaping women's expectations of birth? What effect does women's childbirth knowledge have on their interactions with childbirth practitioners? To what extent do women use their knowledge in the exercise of their 'consumer' power? Answers to these questions were sought through the design and implementation of an exploratory descriptive research study in which the primary research question to be addressed was: What is the cultural transmission of childbirth knowledge among nulliparous women?

Significance of the Study

Over the past several decades it has become commonplace for nulliparous pregnant women to enrol in prenatal education classes as one strategy among many of learning about what to expect during childbirth. Although a sizeable industry has been built to cater to women's prenatal educational needs, much of the information delivered to pregnant women has been designed prescriptively to fulfil presumed needs (O'Meara, 1993). A good deal of research has been conducted to assess the effects of formal prenatal education on birth outcome and on childbirth expectations, but few researchers have acknowl-

edged that women acquire information from a variety of sources, not solely from prenatal classes. Advocates of competing models of childbirth, whether prenatal class teachers, authors of popular childbirth literature, or television and film script writers, disseminate conflicting information about what childbirth is like. The result is that pregnant women, particularly those who are pregnant for the first time, are exposed to an array of contradictory information. Little is known about the extent of women's childbirth knowledge, the context in which they acquire it, or the influence it has on shaping their concepts and expectations of birth. Yet women's childbirth knowledge is a major factor contributing to the definition of appropriate childbirth practice. Therefore, this study was designed to explore and describe the cultural transmission of childbirth knowledge among nulliparous women in the prenatal period in the anticipation that it would significantly enhance our understanding of the source and the substance of information which influences women's concepts and expectations about birth. The findings of this study will provide some insight into how women's childbirth knowledge becomes a factor in the definition of culturally appropriate childbirth practice.

In the following chapters, factors pertinent to the theoretical approach and methods used in implementing this research study will be discussed. In Chapter II, I will review the literature which in some way provides evidence for the cultural transmission of childbirth knowledge. In Chapter III, the theoretical orientation and the research methods will be outlined and discussed. Chapter IV consists of a presentation of the research findings and liberally uses quotes from the interview subjects to illustrate the cultural patterns in the transmission of childbirth knowledge. A discussion of the implications of the findings and conclusions drawn from the research will be presented in Chapter V.

Notes to Chapter I

1. This is not to suggest that there was no precedent for the modern incarnation of the childbirth 'consumer' movement. To the contrary, throughout this century organized groups of women lobbied to gain access to analgesics such as "Twilight Sleep" (Sandelowski, 1984; Beinart, 1990) and have lobbied to have access to hospitalized childbirth (Langford, 1994). In other words, "'consumer' groups" have a long history of defining what they consider to be appropriate childbirth practice.

CHAPTER II - LITERATURE REVIEW

Introduction

In this chapter I have reviewed several diverse bodies of literature, beginning with consideration of the merits of various theoretical approaches to cultural transmission and their usefulness to the present study. The discussion will then turn to a brief summary of the history and ideology of prenatal education programs, and the development of two opposing models of childbirth education, each of which manipulates childbirth knowledge in the pursuit of competing agendas. A review of the literature in which researchers have examined and analyzed the efficacy of formal prenatal education programs will ensue. The assumption that formal prenatal education programs are the primary source of women's childbirth knowledge is subsequently challenged through a review of literature which demonstrates that women acquire childbirth knowledge from a variety of sources. Finally, I will conclude the literature review with an examination of the few anthropological studies that have dealt with the cultural transmission of childbirth knowledge.

Cultural Transmission

Anthropologists who have studied cultural transmission have traditionally placed an emphasis on the methods of information delivery, the setting, and the implicit and explicit content of information transmitted to the (cultural) neophyte (Pelissier, 1991). Some criticism of this approach has been raised by anthropologists who feel that researchers need to be as concerned with cultural acquisition as they are with cultural transmission (Wolcott, 1987 & 1991; Pitman et al., 1989; Goodenough, 1971; Pelissier, 1991). They argue than an emphasis on transmission implies passiveness on the part of the learner, and further that the substance of information transmitted cannot be considered to be equivalent

to the substance of the information received. Counter criticisms of the cultural acquisition arguments include: first, that the term cultural transmission implies cultural acquisition since an anthropological axiom is that culture is learned; and second that the object of researchers in cultural transmission studies should be to focus the "intentional intervention" one group of social members makes to ensure another group of social members learns culturally appropriate ways of thinking and behaving (Spindler & Spindler, 1987, 1991). They further argue that a focus on cultural acquisition threatens to make the "individual" the object of study rather than the group (Trueba, 1991). Despite these objections, there is agreement that through the process of cultural transmission (whether in the form of intentional intervention or not), the individual actively selects, tests, reformulates, constructs and perpetuates recognizable cultural patterns.

Pitman et al. (1989) prefer the term culture acquisition rather than cultural transmission on the grounds that culture acquisition is a broader concept which encompasses more than the study of teaching and learning in formal schools settings, the study of informal teaching and learning, or the study of child rearing practices. These authors define culture acquisition as a "metaphor in which all learners are viewed as active agents selecting options within a probabilistically constructed, socioculturally, ecologically patterned process" (p. 3). They argue that individuals are shaped by structures and processes of the whole sociocultural life in which they are immersed. According to their operationalized model, learning takes place in circumstances consisting of the culturally patterned setting, activities, objects, group composition, content, responding persons, and values and ideals, all of which the active learner deposits as knowledge. I considered the General Theory of Cultural Transmission developed by Marion Lundy Dobbert (1982) and discussed by Pitman et al. to be an excellent model for this research

study, particularly because it provides a method of accounting for the transfer of knowledge whether that transfer occurs as the result of "intentional" intervention or not.

Whether one refers to the process as culture acquisition or cultural transmission, the learning of cultural patterns appears to proceed via the acts of observing and listening, building social relationships, gradually gaining competency with specialized language and/or tools, applying acquired knowledge to tasks, and relying on the experience of action and interaction to reformulate acquired knowledge (Pelissier, 1991). This learning process is probably characteristic of the way in which Canadian women learn the cultural patterns associated with childbirth. They listen to or read reports of birth, they observe birth (on television or in film), they build a relationship with their birth practitioner in which an exchange of information takes place, they attend prenatal classes in which they learn the specialized language and tools used in birth, they apply their acquired knowledge to the task of giving birth, and they reformulate their concepts of birth based on their experience.

Paradoxically, women who are pregnant with their first child are expected to gain competence with all elements of this process without ever having had the opportunity to apply their knowledge to the act of giving birth. In their prenatal negotiations with their birth practitioners, nulliparous women's definition of appropriate childbirth practice is therefore based on their concepts and expectations of birth, rather than on their experience. In formulating their concepts and expectations, these women must make judgements about the credibility of the substance of conflicting information, and those judgements may be value dependent on the culturally ascribed status of the source of that information.

History and Ideology of Competing Models of Childbirth Education

As I discussed in the introductory chapter, the idea of prenatal education was first introduced by Grantly Dick-Read, a British obstetrician who recognized that the cultural transmission of childbirth knowledge among women was an essential factor which contributed to the definition of appropriate childbirth practice (Dick-Read, 1953). Dick-Read theorized that through the process of cultural transmission, "civilized" women learned to fear birth and that their fear in turn created tension in the body which interfered with uterine contractions, and thereby caused the very pain they feared. He ethnocentrically argued that "primitive" women did not experience pain in childbirth (contra Spencer, 1986; Mead & Newton, 1967; Jordan, 1993) and construed this to mean that childbirth in its "natural" state was therefore not painful. To interrupt the fear-tension-pain cycle, Dick-Read advocated that women be educated about the physiological facts of birth. His unsubstantiated assumption (Beck et al., 1979) was that cognitive awareness of the birth process would reduce fear, which in turn would promote relaxation rather than tension, and would thereby eliminate painful childbirth and produce "natural" childbirth.

Dick-Read argued that safer childbirth would result if physicians addressed the true cause of pain (fear), rather than looking for treatments to pain (anaesthetics and analgesics). In his review of the medical literature, he demonstrated that pain medication often produced harmful complications and entailed other interventions such as forceps. He further argued that the use of pain medication interfered with the natural euphoria of childbirth. In a nutshell, the two-fold purpose of Dick-Read's method of childbirth education was to transform women's concept of childbirth in order to reduce their requirement for harmful drugs and to enhance their experience of childbirth.

> "The best and safest anesthetic is an educated and controlled mind...Let the obvious contra-indications to the teaching of anesthesia for all be summarized: (1) No satisfactory anesthetic for all cases has been discovered. (2) No anesthetic is free from danger to mother or child. (3) All narcotic agents are injurious to babies during birth; they are all more or less severe respiratory depressants. (4) In normal labor, properly conducted [*i.e. Dick-Read's method*], a high percentage of women do not wish for anesthetic. (5) Anesthesia essentially converts a normal physiological process into a pathological state with its attendant risks. (6) Owing to the ease of the administration of anesthesia, interference at birth is more common than formerly [*i.e. increased use of forceps*]...(7) Anesthesia prevents the occurrence of some of the natural phenomena of labour upon which the safety of both mother and child may depend. (8) Anesthesia, contrary to a woman's desire, robs her of the natural reward of a perfected function, and renders surgical an event which many women believe is the physical manifestation of a spiritual experience (Dick Read, 1953:116).

Although Dick Read's 1944 monograph Childbirth Without Fear was published in eight languages, and was revised, enlarged and re-released nine years later, it appears to have had a minimal impact in North America. What this early work may have done, however, was to prepare the North American psyche for the idea of the benefits of childbirth education and "natural" childbirth. The introduction of childbirth education in North America in the form we would recognize today did not occur until 1959 with the publication of Marjorie Karmel's popular book, Thank You, Dr. Lamaze (Karmel, 1965). The Lamaze method of childbirth (referred to by Karmel as the Pavlovian method), had its basis in the work of Soviet scientists who had applied Pavlov's theory of conditioned response to childbirth. Like Dick-Read, both the Soviets and French obstetrician Fernand Lamaze, assumed that childbirth was not inherently painful, but that women were socially conditioned to expect pain and to interpret their sensations of labour as pain (Lamaze, 1970:12; Beck et al., 1979). Promoters of the Lamaze method advocated that women be educated about the physiological process of birth, that women practice simple exercises to prepare the muscles used in

birth, that women use patterned breathing as a conditioned response to labour sensations, and that they be accompanied throughout labour by a person trained in the Lamaze method of childbirth (Karmel, 1965:37-82; Beck et al., 1979).

The dissemination of information about the Lamaze method through the publication of Karmel's book and through discussion of the issue in the *Ladies Home Journal* (Cayley and Mason, 1985) was certainly important, but no less important was her work to establish the American Society of Psychoprophylaxis in Obstetrics (ASPO) with co-founder Elisabeth Bing. With the establishment of ASPO came the ability to certify childbirth educators who could then make the Lamaze method of prenatal preparation an available option for childbearing women (Beck et al., 1979).

The three justifications for the introduction of childbirth education as cited by the originators of these programs was: 1) to reduce the harm which resulted from the unnecessary use of pain medication; 2) to enhance women's euphoric experience of birth; and 3) to put the labouring woman in control of her own labour (Dick-Read, 1953; Lamaze, 1970; Karmel, 1965; Bradley, 1974). From the outset then, the agenda underlying childbirth education has been to reform childbirth practice by re-educating women who use maternity care services. The argument put forth by Lamaze is as follows:

> "A woman must be imbued with the thought that she is essentially responsible for the success or failure of her own childbirth. No doubt, when the time comes, she will have at her side the watchful care she has been promised and to which she is entitled; but she must not cease to be the force which directs, controls and regulates her labour. Her mind, carefully educated, steadfast and alert, will know how to abolish pain" (Lamaze, 1970:17).

The originators of the concept of childbirth education, therefore, did not directly challenge the standard practices of childbirth practitioners. Rather their prescribed methods of childbirth reform took an indirect route by attempting to

subvert, or perhaps convert, women who would otherwise demand or require pain medication during childbirth. This means of indirectly challenging standard medical practice was not only subversive, but also problematic; medical practitioners (physicians) distinguish themselves from non-medical practitioners (midwives) by their ability to intervene. If intervention in childbirth were not required, how then could physicians justify their existence? The subversive agenda underlying prenatal education was of course recognized within medical circles, and it consequently took some years before women's attendance at childbirth education classes became a socially established prerequisite to childbearing.

Over the years, two forms of childbirth education have developed (McBride, 1982; Sargent & Stark, 1989; Gould, 1986; Gilkison, 1991). The first (which can be termed the *compliance model*), implicitly attempts to produce a population of submissive patients. This model exhibits the effects of co-optation since all vestiges of the subversive function of childbirth education have been expunged. Instead of making it more difficult for the use of obstetric intervention, prenatal educators working under this model foster the use of interventions. In fact within this model, prenatal education is not considered to be subversive at all, rather it is justified on the grounds that educated parents are easier to work with and are more accepting of the necessity for (the almost inevitable) interventions. This approach to childbirth education is conveyed succinctly in a popular manual promoting the benefits of Lamaze childbirth:

> [T]he prepared woman is also taught to realize that there is a possibility that for the safety of the baby or herself the doctor may have to intervene at any time. She is ready to give her full co-operation and support to the medical staff working with her. Her primary concern is to deliver a healthy baby; of secondary importance is how she delivers it...the aim of training is not to make childbirth painless but to make it a controllable, positive experience (Ewy & Ewy 1972:3).

The second form of childbirth education (which can be termed the *defensive model*), attempts to produce a population of informed consumers who are knowledgeable enough about childbirth practice to take an active role in the decision making process. The assumption underlying this model is that expectant parents can learn in a relatively short time everything they need to know to enable them to challenge the decisions of exceptionally well educated medical professionals. Prenatal educators working within this model consider that women are the subjects of social control, and seek to empower women by making them medically literate 'consumers' of childbirth services. The message espoused in many of the popular childbirth books is that women who are educated about the various hazards of obstetrical intervention can manipulate standard childbirth practice to suit their individual needs (Feldman, 1978; Stewart and Stewart, 1977; Korte and Scaer, 1984; Howe Elkins, 1983, 1985; Cohen & Estner, 1983; Sinclair, 1989). Women are advised to shop around until they find physicians and hospitals who agree to forego routine intervention, and who agree to provide the type of maternity service requested by the 'consumer.' This approach to childbirth education is evident in the following quotation taken from a defensive model childbirth manual:

> We give you a sometimes startling summary of medical research regarding childbirth today - as well as a first-ever report of what 2,000 women say they want in hospital births. We show you why what many women label the "good" birth is also the "safe" birth for you and your baby. We describe the appropriate use of high-tech childbirth interventions based on scientific data, not myth. And, most importantly, we tell you how to get the birth you want, step by step, by finding and working with Dr. Right; why and how to hospital-shop; and what you need to know about nurses to get good care once you're in the hospital (Korte & Scaer, 1984:1).

These two forms of childbirth education orient the respective prenatal educators (whether teachers or authors) in opposite directions: in the first, the prenatal educator minimizes the risks of interventions, and demonstrates that

any interventions that do occur, occur only because they are necessary; in the second the prenatal educator maximizes the risks of interventions, and demonstrates that interventions routinely occur whether or not they are necessary. Given these biases, one would expect that the second form of childbirth education could actually foster more anxiety and fear since it may undermine the expectant parents' confidence in their care givers. On the other hand, the minimization of the risks of intervention is detrimental to those who experience iatrogenic morbidity, and we must be attentive to the possibility that the experience of morbidity increases parents' anxiety and fear of subsequent births.

Regardless of their respective orientations, the effect of both forms of prenatal education has been to transform women's concepts of birth according to the medical model. This is what Barbara Duden calls teaching women to experience their bodies as "scientific fact" (Cayley, 1991). Indeed, in a controlled study which compared prenatally educated women with non-prenatally educated women, Tanzer (1972) demonstrated that the prenatally educated women were more amenable to, and accepting of, standardized care. Unlike these women, the women who were not prenatally educated were less willing to accept such procedures as vaginal exams (p. 102). Although Tanzer found that attendance at prenatal classes significantly enhanced women's birth experiences, that satisfaction can in part be attributed to their advanced knowledge and acceptance of the actions of the birth attendants.

Both forms of childbirth education purport to help women achieve control over the childbirth experience, but this "control" can only be achieved within the medicalized framework of childbirth. Although both models of childbirth education appear to have hidden agendas, those agendas are not in any way malicious (even if the methods used may be coercive). Rather, both groups appear to have women's best interests at heart. Childbirth educators adhering to compet-

ing models make information readily available to pregnant women, but it is the women themselves who actively accept or reject the information that is offered.

Sources of Childbirth Knowledge

Popular Childbirth Literature and Electronic Media

Evidence to suggest that women rely on popular childbirth literature as a source of information was revealed in a national British study which surveyed 1508 women postnatally to discover the consumer's view of the usefulness of various types of information (Jacoby, 1988). Of the total sample, 628 were first time mothers who reported obtaining childbirth information from books (78%), electronic media (43)%, family (60%), friends (60%), and health care professionals (43%) as well as from childbirth education classes (55%). This study provides ample evidence to suggest that British women are exposed to childbirth information through popular literature and electronic media, although the orientation of the media's message remains unclear.

The British women did not cite this material as a primary influence in their construction of concepts about childbirth in contrast to the women in an American study, 20% of whom reported reading material as their primary influence (Sargent & Stark, 1989). Although both of these studies indicate that the media influenced childbirth concepts, neither of the studies offers insight into precisely how women's concepts are influenced by the media. One must remember that in addition to the media which concerns itself directly with providing factual information about childbirth, messages about childbirth are also incorporated in television dramas, films and novels (McCreary-Burke, 1993). Such messages are not necessarily factual, but may be used as dramatic or comedic devices and may often portray childbirth as a traumatic panic-filled crisis. The extent to which these more subliminal messages

affect women's concepts of childbirth is not addressed by any of the studies.

Informal Sources of Information

Women's reliance on their informal networks for information about pregnancy and birth was found in an American study in which the researcher interviewed eight primigravidae of low socioeconomic status aged 18 to 22 (Kinnard, 1984). Only one of the informants had attended prenatal classes, and all the informants relied on informal sources for information about pregnancy and birth. The informants appeared to have placed minimal value on the information they acquired from professional sources, insisting that they already knew what was good for them. The respondents were particularly sceptical of the information provided by professionals about proper diet, exercise and expected due dates. These women were not unconcerned for their own health or for the health of their babies, but felt the information provided by their mothers and friends and their knowledge of their own bodies was more correct than the information provided by professional sources. When discussing the topic of labour and birth, pain arose as a major theme. Respondents expressed the fear that they would not be able to cope with the pain, and reported that pain was frequently discussed with friends who had already given birth. Respondents were reported to have little idea about what labour entailed other than that it involved pain.

The author of this study seemed frustrated that her informants did not express a desire to learn from experts about nutrition, exercise, and the physiology of birth, yet the manner in which the interview questions were phrased virtually guaranteed this result. Unfortunately the researcher attempted to assess the childbirth learning needs of women by asking them to enumerate the areas of expert advice from which they thought they could benefit. What this study does show, even if inadvertently, is that this group of

women did not recognize expert knowledge as being more valuable than the knowledge provided by their informal networks.

Prenatal Education Classes

Although prenatal education classes are not the only source of information for women seeking childbirth knowledge, they continue to be extremely popular among pregnant women. Primiparous women's motivation for attending Lamaze classes was investigated in an American study using an unstructured interview administered prior to the commencement of prenatal classes (McCraw & Abplanalp, 1982). The respondents [n=77], who were encouraged to name more than one motivating factor, most commonly cited their desire to gain information (42.9%) as a motivation for enroling in classes. Other motivations reported by respondents are consistent with the types of information prenatal education classes address: 24.7% indicated their desire to decrease the use of medication during childbirth; 20.8% reported the desire to involve their husbands in the birth; 15.6% reported the desire to be an active participant in the birth or make it a more enjoyable positive experience; 14.3% indicated a desire to decrease anxiety or increase confidence during birth; a mere 7.8% reported their desire to decrease pain or make childbirth easier; and finally 19.5% of responses were categorized as miscellaneous motivations such as the recommendation of friends, or wanting to give birth the "right way." When asked to indicate what or who influenced them to enrol in prenatal classes, most responses [58/77] revealed that women were influenced by non-professionals such as family and friends.

Another study confirms this research on women's motivation for enroling in prenatal classes (Sargent and Stark, 1989). Of a sample of 84 couples, 85% were experiencing their first pregnancy. Interviews conducted in the prenatal period revealed 49% of attendants were seeking information about

labour and birth, 14% indicated a desire to improve the quality of their labour, and 17% wished to ensure the participation of their husbands during childbirth. In contrast to the findings in the Lamaze study discussed above, women reported being more influenced by recommendations from professional sources in their decision to attend classes, although convenience and not ideological orientation was the major reason cited for enroling in a particular class.

The literature which examines the efficacy of prenatal education is only marginally helpful to the present study, and then only because it points to the deficit in our knowledge about the effects of prenatal education. Many studies have been conducted to evaluate childbirth education classes and to assess whether prenatal education can actually deliver what it claims to deliver (Astbury, 1980; Crowe & von Baeyer, 1989; Gould, 1986; McIntosh, 1988; Vinal, 1982). Researchers have tended to distinguish between attenders and non-attenders of childbirth education classes and have posited relationships between the factors of knowledge, expectations, anxiety, fear, pain, satisfaction, socioeconomic status and maternal and neonatal outcome. The results of these studies appear to be inconclusive, and in some cases contradictory (Lindell, 1988). If nothing else, the assumption that prenatal education is a homogenous entity dooms these studies to failure. Much of this research does not take into account the fact that there are a number of competing prenatal education programs which teach a variety of techniques and which hold differing ideological perspectives. Even within the same style of program, different teachers will have idiosyncratic teaching methods which will be more or less successful. Moreover, there is an assumption that prenatal class attenders are automatons who have learned and are willing to put into practice the pain reducing strategies that are taught in prenatal education classes. Much of the research also assumes

that prenatal classes are the primary, or at least the most important source of information.

Assessment Prenatal Class Attenders' Childbirth Knowledge

A study which assessed the childbirth knowledge and interests of registrants in Early Bird prenatal classes in Edmonton (Mills et al., 1982), offers insight into the types of information women seek in the prenatal period. The researchers assessed the degree of interest the class participants had in each of the curriculum topics and the degree of knowledge the participants felt they possessed about each of the topics. An open-ended question allowed the participants to suggest topics they would like the prenatal classes to address.

The results of this study indicate that even early in pregnancy the topic of most interest to registrants in childbirth education classes was information pertaining to labour and birth. The registrants also indicated that their present level of knowledge on this topic was lower than that on any other topic. In answering the open-ended question, the participants more often identified topics related to labour and birth as those that should be addressed in the prenatal education curriculum. Paradoxically, the participants' ability to articulate the specifics of what they wanted to learn about labour and childbirth revealed that their levels of knowledge were not nearly as low as they claimed. This may indicate that women lack confidence in their (non-technical) knowledge.

By the time women have completed or nearly completed a course of prenatal education they appear to have gathered a good deal of knowledge about childbirth and to have generated concepts and expectations about birth. A study conducted in Winnipeg which used data gathered from interviews with eleven attenders of prenatal classes found that women's expectations were often unrealistic and romanticized (Beaton & Gupton,

1990). The researchers pointed out that although women claimed they did not know what to expect from birth, they were able to give detailed descriptions of the birth environment, the role of their "coach" and the roles of professional care givers. Women were aware of the various technological interventions used in childbirth and although they hoped interventions would not be used, they expressed an inability to control this aspect of the birth. Pain and fear of pain were major themes which emerged from the data, and women's description of the pain they would experience was reported to be "gruesome...such as chopping off two fingers" (p. 135).

The researchers suggested that by seeking information from prenatal classes and developing expectations about birth, women are working through their fears and anxieties about childbirth. They warned, however, that women may be developing birth fantasies which are inconsistent with reality and which predispose them to feelings of disappointment with birth.

Cultural Transmission of Childbirth Knowledge

The results of a number of studies (implicitly or explicitly) concerned with the cultural transmission of childbirth knowledge, are pertinent to this study. In keeping with the traditional orientation of cultural transmission research, most of these studies have focused on instances of "intentional intervention" in the transmission of childbirth knowledge. Notably, an ethnographic study of learning which occurs during obstetric training (Davis Floyd, 1987), and a content analysis of obstetric textbooks (Hahn, 1987) have provided rich descriptions of the production and perpetuation of authoritative childbirth knowledge among obstetricians. In two other studies, the dissemination to the public of authoritative definitions of childbirth is explored through content analyses of childbirth pamphlets (Perkins, 1980), and of childbirth films shown in sex education classes (Prendergast

& Prout, 1990). Although this research is important for increasing our understanding of the medical definitions and values underlying childbirth practice, it would be a mistake to assume that medical definitions of childbirth are the only definitions that are transmitted.

A content analysis (conducted by the present author) of six portrayals of childbirth on Canadian television, revealed that both the medicalized model of childbirth and the (politicized) alternative model of childbirth are frequently depicted (McCreary-Burke, 1993). This study was motivated by the author's observation that women occasionally cite television portrayals of birth (particularly the alternative model) as having influenced their childbirth decisions. Other researchers have conducted ethnographic studies of prenatal classes and sex education classes, and have discussed the transmission of implicit and explicit messages in these settings (Perkins, 1980; Sargent & Stark, 1989; Prendergast and Prout, 1990). In two of these studies, the researchers conducted interviews with participants in the classes in an attempt to discover the participants' reactions to the material. Both these studies were as concerned with "acquisition" as they were with "transmission."

In the first of these studies, two anthropologists tested the hypothesis that medical messages in childbirth education are a form of social control. They unexpectedly found that women were more influenced by information gathered from their informal networks than they were by the information presented in the prenatal classes (Sargent & Stark, 1989). Approximately half of the 84 participants in this study were enroled in each hospital-based (compliance model) and community-based (defensive model) prenatal classes. The study focused on the degree to which the two types of prenatal education influenced women's concepts and expectations of birth. Interviews were conducted to elicit women's attitudes toward pain medication and other technological interventions and to determine the

major influences on those attitudes. The participants reported that pain was a major theme which emerged when family and friends had discussed their own childbirth experiences. The authors found that even though the community based prenatal classes discouraged the use of medication during labour, 73% of community class women interviewed prenatally expressed a positive orientation toward having pain medication. The researchers noted that the women appeared to reinterpret information about the risks of medication to make it consistent with their pre-existing concepts regardless of whether they attended the hospital classes or the community classes. Three quarters of the 54 women re-interviewed postnatally, indicated that prenatal education had not changed their attitude toward any aspect of birth.

Although this study is informative, it has some methodological problems. One cannot unequivocally accept the researchers' conclusion that prenatal education appeared to have very little influence on women's preconceived ideas, since interviews on this topic were not conducted prior to women's attendance at prenatal classes. Furthermore, the researchers' finding that women's concepts of birth were not consistent with the information given in prenatal classes cannot be construed to suggest that women's concepts remained unchanged by prenatal education. This conclusion could be drawn only if interviews took place before women had begun, as well as after women had completed a course of prenatal education. Although this study suggests the importance of women's pre-existing beliefs about childbirth and the tremendous influence of informal sources of information, it does not adequately demonstrate the extent of those pre-existing beliefs nor the impact of various forms of information on those beliefs. Unfortunately this study confirms, rather than refutes, the conclusion of a recent Canadian study which suggested that little is known about the impact of childbirth

education on women's concepts and expectations of birth (Gupton et al., 1991).

The authors of the study of childbirth films shown in sex education classes conducted participant observation and interviewed both the children and the teachers about their reactions to the films. They noted that the adults considered it unsettling to show the films, and that the children found them unsettling to watch. Based on data derived from the interviews, the researchers confirmed their observation that the children had been uninterested in the detailed sequences which portrayed fetal development. The actual birth generated more interest, and at the point where the woman gave birth, the researchers observed the boys making jokes and snickering, and observed the girls averting their eyes. In the interviews, the girls proved to be very interested in the birth process, but felt that the film was dishonest and seemed disconnected from the pain the woman was feeling. Many of the girls concluded it would be better to have a caesarean section under anaesthetic rather than to experience the pain of birth. The authors noted that the girls' emphasis was on trying to discern how the woman was feeling whereas the boys (in accordance with the message of the film) emphasized the safe and joyous outcome of birth.

Another ethnographic study concerned with women's body image in relation to menstruation, childbirth and menopause reveals that women do not necessarily fully subscribe to the medical definitions of women's bodily functions (Martin, 1987). In this research Martin found that women's behaviour during childbirth episodes were characterized by small acts of resistance to the "rules." For example, one woman kept her labour a secret as late as possible to avoid going to hospital too soon. Other women took long walks in the hospital to avoid being attached to the fetal monitor. These actions are based on women's knowledge of childbirth, and demonstrate that at

least some women exercise their control over childbirth on an individual level.

The actions of the receivers of information, that is, childbearing women, are likely to have a significant effect on both the maintenance and the transformation of childbirth practice. The foregoing analyses of girls' and women's reactions to transmissions of childbirth knowledge suggest that system maintaining decisions were made either in response to, or prior to episodes of intentional transmission of childbirth knowledge. As was demonstrated by the first of these studies, attenders at prenatal class appeared to be unaffected by the information about the risks of pain medication. In the second example, even school girls already "knew" enough about childbirth to consider caesarean section to be a viable means of avoiding pain. Finally, in the third example, women were found to conduct small acts of resistance as a means of avoiding those childbirth practices they thought to be inappropriate.

In a recent anthropological study, Davis-Floyd theorized that the childbearing year is a rite of passage in which the rituals performed during pregnancy, birth and the postpartum imprint technocratic cultural values on childbearing women (Davis-Floyd, 1992). Davis-Floyd's research was based on interviews with a hundred women living in two American cities. Her data is retrospective, the interviewees consisted almost entirely of women who had already given birth at least once, sometimes many years in the past. Although the population of Davis' study differs from the nulliparous population in my study, she gives an insightful analysis of pregnancy as a liminal state. While she focuses on examining the ritual of childbirth, her identification of the rituals that occur and intensify during pregnancy are extremely useful to the present study. Unfortunately Davis-Floyd implicitly pinpoints a woman's awareness of her pregnant state as the beginning of her rite of passage, and she makes no attempt to assess,

acknowledge or account for the childbirth knowledge women learn prior to pregnancy. It is as if Davis-Floyd considers the newly pregnant woman to be a "blank slate" on which cultural values will be written during the childbearing year.

In another recent anthropological study, again conducted in the United States, Lazarus assessed the substance of the childbirth knowledge held by women and used by them to make decisions and choices in childbirth (Lazarus, 1994). Lazarus noted that the participants in her study described childbirth as "natural" while at the same time conceptualizing childbirth in medicalized terms. In her findings Lazarus suggested that women "'buy' the myths of technology understandably confusing medical facts with medical ideology created and believed by the medical profession" (p. 29). In other words, she found that the women in her study accepted the medical definition of the situation and through their actions upheld the practice of medicalized childbirth. Lazarus, remains highly critical of the constraints medicalized childbirth places on women's abilities to make choices and suggests that consumers are dissatisfied with these constraints.

In Lazarus' article, indeed in much of the literature here reviewed, medical practice and medical technology are construed as having perverted the definition of childbirth. Concomitantly, birthing women are construed as dupes who "buy into" the medical definition. Yet Lazarus does not consider that birthing women may have much loftier expectations of the wonders of modern medicine than do the practitioners trained in that discipline. Therefore, rather than 'buying into' medical ideology, birthing women may be equally responsible for creating and maintaining that ideology.

Women's dissatisfaction with medical practice may result from the inability of medical practitioners to fulfil unrealizable ideals. Indeed it is interesting to ask whether women expect medical practitioners to take the "hands-off" approach consistent with the philosophy of "natural childbirth," or

whether women categorize "natural childbirth" in the same class as "medicalized" childbirth. If they do not so categorize "natural childbirth," then the question is: If women want "natural childbirth" why do they engage practitioners who are trained to intervene? (Davis-Floyd, 1987; Harrison, 1983). The unrealistic ideal would then be the expectation that "hands-on" practitioners will take a "hands-off" approach to childbirth. If this is the case, then it should not be surprising that some proportion of women are dissatisfied with their experiences of childbirth.

Summary and Conclusions

Although standard childbirth practice has changed, and continues to change in the direction favoured by childbirth advocates,[1] it also continues to have high rates of medical intervention.[2] This is a rather odd state of affairs in light of the evidence which suggests that routine intervention compromises society's moral requirements for safety and autonomy and may increase a woman's pain (Young, 1983; Brackbill, 1984; Cohen & Estner, 1983; Jordan, 1993:121-128). Clearly, the forces operating to transform childbirth practice are offset by the forces operating to maintain childbirth practice. Given that childbearing women's behaviour influences the definition of appropriate childbirth practices, one of those forces working to transform or maintain childbirth practice may be the transmission of childbirth knowledge among nulliparous women.

The cultural transmission of childbirth knowledge appears to occur within a woman's active search for information, her critical assessment of that information, her act of incorporating new information with existing concepts culminating in her generation and revision of concepts and expectations of birth. In a review of the literature, the many sources of information on which women rely have been identified (Jacoby, 1988; McCraw & Abplanalp, 1982; Sargent & Stark, 1989;

Kinnard, 1984). There is further evidence in the literature that childbirth education classes differ ideologically as well as in style (Sargent and Stark, 1989). These differences extend to other sources of information, be they professional advisors, family, friends or electronic and print media. Indications appear in the literature that women who attend prenatal classes assess themselves to have low knowledge levels early in the prenatal period (Mills et al., 1982), they seek to acquire information about labour and childbirth during pregnancy, and by late pregnancy, they have developed detailed concepts and expectations about what childbirth will be like (Beaton & Gupton, 1990). The extent to which their concepts and expectations are influenced by attending prenatal classes remains unknown (Sargent & Stark, 1989, Gupton et al., 1991). Preparing for birth involves a woman's efforts to accumulate information from various sources; it involves attempts to discover her expected social role in relation to others; it involves trying to put together a picture of what it will be like to give birth; and it potentially involves negotiating with health care professionals to ensure the birth experience will conform to developing expectations.

This study of the cultural transmission of childbirth knowledge among nulliparous women will significantly enhance our understanding of the source and the substance of information which influences women's concepts and expectations of birth and will further provide insight into how women's childbirth knowledge may become a factor in the definition of appropriate childbirth practice. Nulliparous women are socially expected to learn about birth and are highly motivated to learn about birth from a variety of sources. Not only are they the most likely group to attend prenatal education classes, but with the declining birth rate, nulliparous women comprise a significant proportion of all childbearing women in Canada (Rao & Balakrishnan, 1989). Therefore, this study of cultural transmission of childbirth

knowledge among nulliparous women will increase our understanding of one of the mechanisms whereby childbirth practice is either maintained or transformed.

Notes to Chapter II

1. For example, consumer demand has been largely responsible for the recent initiatives to regulate midwifery practice in the provinces of Ontario, Alberta, British Columbia, and Manitoba. Other changes in childbirth practice include the implementation of home-like decorating schemes in hospital birthing rooms, the attendance of the husband and other family members and friends at birth, and the introduction of birthing beds and chairs, to name just a few.

2. The rate of caesarean operations, electronic fetal monitoring, inductions, and episiotomies remain high in Canada when compared to those of many other Western nations (Milne et al., 1991; Sinclair, 1989; Alberta Health, 1993; Alberta Medical Association, 1994).

CHAPTER III - METHODS

Rationale

This study was undertaken to explore and describe the cultural transmission of childbirth knowledge among twenty-four nulliparous women residing in or near the city of Edmonton, Alberta. As was previously discussed, the extant literature on this subject has emphasized primarily and almost exclusively the learning and teaching that occurs in formal prenatal education programs. There were indications in the literature, however, that suggested the cultural transmission of childbirth knowledge occurs in the course of daily living and is most intense during a woman's first pregnancy. Further, pregnant women, particularly those who are pregnant for the first time, are exposed to an array of contradictory information during the prenatal period. The literature also revealed that little was known about the extent of women's childbirth knowledge, the context in which they acquire it, or the influence it has on shaping their concepts and expectations of birth. Yet women's childbirth knowledge is a major factor contributing to the definition of appropriate childbirth practice. Therefore, this study was conducted with the intent of enhancing our understanding of the source and the substance of information which influences women's concepts and expectations about birth, and in the anticipation that it will provide some insight into how women's childbirth knowledge becomes a factor in the definition of culturally appropriate childbirth practice.

Research Design

Theoretical Considerations

An exploratory, descriptive research design was formulated in accordance with Dobbert's (1982) General Theory of Cultural Transmission which posits that the content of what is learned cannot be divorced from the context in which it is

learned. The rich cultural contextualization accompanying the transfer of information imprints value on that information; the context enables one to interpret information and to make decisions about whether the information itself is more or less important, more or less believable, more or less confirming of what one already knows. The context is therefore inseparable from the content; the two are inextricably linked. Cultural transmission is the process whereby members of society emit and receive culturally contextualized messages and through which individuals become culturally knowledgeable beings.

Definition of Terms

The *Cultural Transmission of Childbirth Knowledge* is the process whereby nulliparous pregnant women locate, select, modify and hold certain values, concepts and expectations about the experience of childbirth. This includes concepts and expectations of the sensation of pain. It includes knowledge of the emotional, psychological and spiritual aspects of birth and the effects of emotional and physical support given by others. It includes knowledge of childbirth interventions, particularly the use of medication and instruments. Finally, it includes knowledge of the environment of the birth setting.

Methodological Considerations

When conducting ethnographic research, anthropologists have traditionally relied on the methods of participant observation, ethnographic interviews and archival research (Pelto & Pelto, 1981). The use of (at least) three methods of data collection has enabled anthropologists to compare one source of information against another. For example, archival research may be conducted to obtain demographic and historical material and may provide insight into data collected through other means. A second method, that of participant observation, not only generates questions to be asked of informants,

but when used in conjunction with the ethnographic interview, provides the anthropologist with opportunity to discover the degree to which actual behaviour conforms to cultural ideals (Spradley & McCurdy, 1972:9). The ethnographic interview is useful in that this method allows the cultural neophyte (anthropologist) to elicit explanations from the culturally adept (the informants) of behaviours and concepts observed in a particular cultural milieu. This method is nevertheless inherently problematic because it relies on the good will of reliable informants, and furthermore, data collected in this manner may reflect cultural ideals rather than reality. The ultimate goal of the anthropologist is to use each of the methods to create a whole, integrated ethnographic picture.

I recognized from the outset that data pertinent to the research topic would be most effectively elicited using the method of semi-structured interviews rather than the methods of participant observation and archival research. The best method for discovering how nulliparous women came to know what they know about childbirth was to ask them. This is not to deny the utility of the other methods, nor to suggest that these methods were entirely discarded. Indeed, review of the popular and scholarly literature aided my formulation of the semi-structured interview schedule which was eventually used to elicit data. Furthermore, I reviewed the books, films and television programs the women had cited as sources of childbirth knowledge whenever this was possible. My previous research conducted over the past several years has helped to provide the essential social, political and historical context for this study. This includes an analysis of portrayals of birth on Canadian television, an analysis of the discussion of birth issues in popular Canadian magazines dating from the 1920's, interviewing women who chose to give birth at home, and observing prenatal classes. Finally, non-research based participation in childbirth activist groups as well as my own

experience giving birth, learning about birth, and providing labour support have kindled and inspired this research study.

The research question, "What is the process of cultural transmission of childbirth knowledge among nulliparous women in Edmonton?" imposed limits on both the research design and the methods of data collection. Although Dobbert's (1982) theory lends itself equally well to the data collection methods of participant observation and interviewing techniques, I considered participant observation to be an inappropriate method for use in this study. Participant observation is appropriate in cultural transmission studies limited to particular settings, for example if one were only interested in the teaching and learning that occurs within the confines of prenatal classes or sexual education classes. The goal of this study however, was to elicit retrospective data pertaining to women's acquisition of childbirth knowledge. I therefore selected semi-structured interviews as the most appropriate method of data collection for this research project. Demographic data were gathered through use of a questionnaire.

The research study was designed such that one interview each would be conducted with equal numbers of women during each of three stages of pregnancy: women in their second to fourth month of pregnancy; women in their fifth to seventh month of pregnancy; and women in their eighth to ninth month of pregnancy. Note that this research design does not test the assumption that women accumulate childbirth knowledge over the course of the pregnancy. To do this, it would require repeated interviews with the same subject. This research design allowed me to interview women at all stages of pregnancy and provided a structure which enabled me to make comparisons of knowledge acquisition throughout pregnancy.

Research Participants

Selection Criteria

Twenty-four voluntary research participants were recruited from the city of Edmonton and environs through advertisements in the Edmonton Examiner (see Appendix I), through advertising flyers distributed for me by the Association for Safe Alternatives in Childbirth, and through referrals from my acquaintances and other study participants. The criteria for the sample selection were:

1) The sample was to include only pregnant women aged 20 to 35 who had never before given birth.
2) Eight women were recruited for each of three stages of pregnancy; early (second to fourth month of pregnancy), middle (fifth to seventh month of pregnancy), and late (eighth to ninth month of pregnancy).
3) Prior to the interview, the research participants were required to indicate their willingness to participate in the study, including a willingness to be audio-taped during the interview.
4) Only research participants who were able to speak English were recruited.
5) Only women who intended to attend or who had attended prenatal classes were to be recruited for the study.

Recruiting Techniques

The study was originally designed to recruit through newspaper advertisement voluntary research participants who were not affiliated with any agency. Provision was nevertheless made to use "snowball sampling" in the event the primary recruiting technique failed. I placed advertisements in a local weekly newspaper beginning the third week of September, 1993 and ending the last week of November, 1993. In the initial stage of the project, I found that potential research

participants were reluctant to leave a message on my answering machine and I thereafter made an effort to answer the telephone whenever possible. Recruitment through newspaper advertising did not become successful until the third week after the project had begun.

When it appeared that the newspaper advertisement would not be successful, I approached the Association for Safe Alternatives in Childbirth and requested that they distribute an advertising flyer (Appendix I) at two public events well attended by pregnant women (the Welcome Wagon Baby Shower, and the Edmonton Women's Show). I also approached several friends and acquaintances and asked for referrals to pregnant women. Similarly, once study participants were recruited, they were asked if they could refer me to other pregnant women.

The women recruited to participate in this study were all voluntary, however approximately two-thirds of the research participants were self-selected (i.e. responded to advertisements) and one-third were recruited through "snowball sampling." Of the self-selected group, thirteen women responded to the newspaper advertisement and four women responded to the advertising flyer distributed during public events. Of the "snowball sampling" group, four women were referred to me by friends and acquaintances and three study participants each referred me to one of their co-workers.

Each of the recruiting methods had advantages and disadvantages and it is hoped that by using several techniques the disadvantages of one were offset by the advantages of another. Recruiting through newspaper advertising ensured the anonymity of the research participants, and increased my liberty to thoroughly describe the elicited data. Furthermore, this technique reduced the possibility of recruiting research participants from the same 'knowledge network' as would be the case if the participants lived in the same neighbourhood, worked at the same place of employment or attended the same prenatal classes. The major disadvantage of

this method was that self-selected research participants may have qualitatively different knowledge than is true of the population of nulliparous women. Similarly, recruiting through advertising flyers retained all the advantages and disadvantages of newspaper advertising, with the added disadvantage that it put the research study at risk of being associated with the agency distributing the flyers. In contrast, the method of "snowball sampling" resulted in a loss of the advantages gained through advertising. Research participants recruited via this method did not have the anonymity of the other participants, rather the person who made the referral would know, or could find out whether the person had been included in the study. This recruiting technique therefore required me to exercise an extra degree of caution when describing the data in order to maintain confidentiality. Nevertheless, "snowball sampling" was advantageous in that the research participants, although voluntary, were not self-selected. The sample which resulted from using a combination of recruiting techniques should be broader than would be the case with an entirely self-selected group, and should be more representative of the population of nulliparous women. That is not to claim that this sample is representative of nulliparous women in Edmonton or elsewhere; it is merely to claim that the combination of recruiting techniques increases the representativeness of the group than would have been the case if only advertising had been used.

At the time of initial contact with a potential research participant, I ensured that the candidate fit the inclusion criteria. The focus of the study was described to each candidate as was the requirement to be audio taped and the amount of time the interview would entail (Appendix III). Suitable candidates were then asked if they were willing to participate in the study, and a mutually agreeable time and date for the interview was set. After the required number of research participants for each stage of pregnancy were

recruited, the recruitment process for that group ended. Only one potential research participant (a referral) declined the invitation to participate in the study. A further three potential research participants were lost to the study; one went into labour on the morning of the scheduled interview, one was out of the city on the day of the scheduled interview and could not be contacted by me thereafter, and one potential participant rescheduled the interview date twice, then cancelled altogether when it became apparent that no mutually agreeable date could be found.

In four cases, research participants did not fit the original inclusion criteria which had stipulated an age limit of 35, residency in the city of Edmonton or its suburbs, and an intention to attend prenatal classes. All four candidates were nevertheless included in the study. Two of the candidates were older than 35, but given that many of the other research participants were in their thirties, the arbitrary age limit appeared to be an unrealistic restriction. The third candidate did not reside in Edmonton or its environs, but had been raised in the city, was seeing a physician in the city for prenatal care, and was planning to relocate to the city prior to the birth of her baby. Again, it seemed to be unrealistic to not include her in the study. Finally, in one case I failed to ascertain during initial contact with a candidate whether she intended to attend prenatal classes, and I did not discover this error until well into the interview with her. Her reasons for not wanting to attend prenatal classes provided an interesting contrast to the data already collected and offered new insights into what pregnant women know about prenatal classes. To discard this interview would have been a needless waste of very rich data. The research participant was therefore retained in the study.

Data Collection

Using Dobbert's General Theory of Cultural Transmission (1982) as a guide, I formulated an interview schedule which was eventually used to elicit data via a combination of broad, open-ended questions and more specific probes (Appendix IV). Each interview followed a standard format. The research participants were first asked to describe childbirth, including the physical and emotional experience of birth, the birth setting (appearance, furnishings, atmosphere, smell, sound, people present), and the role of the attendants (their actions and the rationale for those actions). The research participants were then asked how they had come to know about the various aspects of birth (where had they been when they learned this? who was present? had they asked or was the information volunteered? how long ago did the incident take place? what did they think about the information, was it credible?). They were then asked if they had ever come across anything about childbirth that was controversial. This served to elicit data pertaining to many common interventions used in childbirth as well as to the issues of midwifery and home birth. Again, they were asked how they had come to know about these aspects of childbirth. Finally, the research participants were asked to outline the advantages and disadvantages of the various aspects of childbirth practice and were asked to elaborate on the circumstances surrounding the acquisition of that knowledge. In other words, as the research participants revealed their knowledge of each aspect of childbirth, I used this as a starting point for the exploration of the circumstances under which this knowledge had been culturally transmitted/acquired. Occasionally if a research participant did not mention a particular aspect that had been revealed in other interviews, I would ask if they knew about *x*. This interview method enabled me to remain sensitive to the uniqueness of each participant's experience of acquiring childbirth knowledge while providing me with an established

theoretical framework to guide my probes for evidence of cultural patterns.

Interviews and Field Notes

Interviews with the research participants were conducted between the first week of October, 1993 and the third week of January, 1994. All interviews but three took place in the women's homes; one interview took place an office at the university, one took place in the woman's parents' home and one took place in a café. The length of the interviews ranged between just under an hour to almost two hours. An audio-tape recorder with a lapel microphone was used to record the interviews. All but three audio recordings are of excellent quality. The lesser quality of the three audio tapes was due to researcher error and equipment failure. Furthermore, equipment failure made it necessary to re-interview two of the research participants. This proved to be a boon as the second interviews (which took place one month and three months later) provided evidence of the dynamic nature of the process of cultural transmission.

A questionnaire was used to gather demographic data and other information pertaining to the research participants' family history (Appendix V). Questionnaires were completed by the research participants prior to beginning the interviews. The questionnaire, transcriptions of the audio tapes, and written field notes formed the data base. I wrote field notes on a standardized form as soon as possible following each interview. The notes contained descriptions the context of the interview including the setting and observations of non-verbal behaviour. I also noted my impressions of the interview, including any aspects of my own performance which may have inhibited effective data collection. Finally, I kept a record of my preliminary thoughts and feelings regarding the gathered data, including making preliminary comparisons with data gathered in other interviews.

I transcribed all audio tapes as soon as possible following each interview, often on the same day or the following day. This method of immediate transcription was extremely valuable, particularly in those cases where the audio tape was of poor quality. Usually the freshness of memory enabled me to complete the inaudible sections during the transcribing procedure by making notes of the gist of the research participant's remarks. The audio tapes netted approximately 650 pages of transcribed data.

Researcher as Instrument

Methodologically, this study reversed typical anthropological research in that it was the interviewees, not me, who were the neophytes in the topic of research. By virtue of having given birth, in addition to both scholarly and personal immersion in the issue for the past eleven years, I simply knew more about birth than the interviewees. This fact created an interesting and potentially hazardous social dynamic, not least because the interviewees knew that I knew more about birth than they did. The relationship I established with the interviewees therefore became important. Rather than approaching the interviews with the smug assurance of someone who knows it all, it was imperative for me to maintain an attitude of respectful curiosity. At the outset of each interview I attempted, perhaps not always successfully, to convey the message that whatever the research participant knew about childbirth was important to the study, that I valued her knowledge, and that I had no intention of asking her trick questions or making judgements about the "correctness" of her knowledge.

As the primary research instrument, I sought to achieve consistency across interviews, however it was not always possible to ask all interview subjects all questions. For example, two of the study participants became very upset near the beginning of their interviews; one in response to a

question about possible discussions with her mother about birth (her mother was deceased) and another in response to a question about what she knew about childbirth (she was "absolutely terrified" at the prospect of giving birth). Although I offered to end the interviews immediately, both women expressed their desire to continue. Not wishing to upset them again, I did not consider it appropriate to probe too deeply for the remainder of the interviews. Other inconsistencies in the interview process revolved around the phrasing of questions. Occasionally I asked what the research participants "thought" or what they had "learned" rather than the pertinent question of what they "knew." These linguistic shifts, imperceptible to me at the time of the interview, were noted when discovered during the transcription and data analysis stages of the research project. Regardless of the way the questions were phrased, it was a revelation to me, and often to the women themselves, to discover, reflect on and articulate what they knew about birth.

Data Analysis

Although I did not begin the data analysis stage of this research project until after the final interview had been completed, a minor amount of analysis proceeded simultaneously with data collection. Following the completion of the first several interviews, interview questions found to be ineffective or confusing were revised and rephrased so that they would elicit relevant data. For example, the question "Have you ever come across anything about birth that you didn't think was true (that you thought was false)?" was changed to "Have you ever come across anything about birth that is controversial?" Other revisions were made to the interview schedule to incorporate topics raised by the research participants in the first several interviews. For example, three of the first four interviewees raised the issues of midwifery and home birth, topics that I had not initially intended to

explore but which nevertheless became of prime importance. Exploration of these topics in subsequent interviews proved to elicit some of the richest data pertaining to the societal values surrounding birth. Similarly, I had not originally intended to explore the issue of the learning that occurs in sexual education classes. The interview with the first research participant, however, alerted me to the probability that this had been an important early source of childbirth knowledge. The issue of the social environment of prenatal education classes took on unforseen importance when it became apparent that there was a consistent, patterned divergence between the expectations held by women who had not yet attended classes, and the experiences of women who had attended classes. This preliminary finding (perhaps indicative of the cultural transmission of ideals rather than reality), prompted me to explore the issue more thoroughly with several study participants. Finally, early in the study a few of the research participants offered their own analysis of the underlying messages about childbirth that are imbedded in television portrayals and media accounts. Thereafter, I began to invite such analysis from study participants.

The essential elements of Dobbert's (1982) theory which had been incorporated into the interview schedule and demographic questionnaire were subsequently used to guide and structure data analysis. Data were categorized according to: 1) **the relevant aspects of the learner** (sibling rank, age or stage of pregnancy at time of transmission, occupational training, etc.); 2) **the ability to act or the appropriateness of the act** (the ability to ask questions about birth; being present when others discussed birth; being included in discussions about birth; etc.); 3) **activities** (situations in which the topic of birth arises either through an event, a conversation, or television portrayal, etc.); 4) **the relevant aspects of the responding person** (the person who transmits childbirth knowledge and their relationship to learner -

parent, sibling, other kin, non-kin, junior, senior or equal, male or female, authority figure, book, television program, etc.) 5) **values** (including judgements made about birth, birth attendants, birthing women, as well as judgements about the credibility of information, and rationale for why childbirth practice is the way it is); 6) **social interaction patterns** (birth is discussed among females/males, within cohort/outside cohort, on the telephone, face-to-face, in groups, at the workplace, on social occasions, etc.); 7) **patterns of control/response** (encouraging/constraining responses to birth as a topic of conversation); and 8) **deposit of cultural knowledge** (what the woman knows about childbirth as a function of items 1 to 7 above).

During the first stage of the data analysis, I listened to each of six audio tapes and made corrections of errors and omissions on the transcripts, including adding details such as laughter and pauses (Field & Morse, 1985:97). After listening to the equivalent of one transcribed page, I inserted a participant code and the page number at the beginning of each transcribed line, I broadly categorized and coded the data according to the source and content of the knowledge, and I copied discrete pieces of the transcribed page to new category files stored on computer disks. A record of the coding process was maintained by writing broad category codes in the right margins of hard copies of the transcribed pages. A hard copy of the entire page was made for each notated code. On each hard copy the relevant data were highlighted and sub-categories were noted in the right margin. I made notes in a journal to keep an ongoing record of the themes arising from the data including the similarities and differences between transcripts. Although this process was extremely time consuming, it was nevertheless invaluable. Listening to the audio tapes helped to imprint the voices and the meaning of the research participants' statements in my mind so that I was usually able to consider discrete bits of transcript within

the context of the entire interview. If I could not "hear" the participant's voice when reading the bits of transcript, reference could be made to the hard copy which kept the context intact. After six transcripts had been thus completed, I generated a table which displayed a list of categories, sub-categories and themes derived from the transcripts. This enabled me to categorize and code the subsequent transcripts consistently.

In the second stage of the data analysis process, I formulated a standardized chart which enabled me to display discrete bits of data across subjects (Miles & Huberman, 1984:151-214). Data was taken from the category files stored on computer disks, and placed in the appropriate section of each chart. The charts were divided vertically by participant, four participants per chart in ascending order of stage of pregnancy. One chart each was devoted to a source of childbirth knowledge (for example, mother, friend, physician, books, etc.). Horizontally the chart was divided into circumstances under which childbirth knowledge was transmitted/acquired and into the content of the transmissions (for example, physical sensation of labour, duration of labour, birth attendants, actions of birth attendants, etc.). The result of this process was that the divided transcripts appear almost in their entirety displayed on charts. Although both massive and unwieldy, the charts nevertheless suggested where comparisons could be made across sources and across stages of pregnancy.

The third stage of the data analysis process enabled me to substantiate inferences made during the first two stages of analysis (Miles & Huberman, 1984:215-248). Again a chart was constructed, but in this case all twenty-four subjects were displayed simultaneously on one chart and a higher level of abstraction was employed. Whereas the purpose of the first set of charts had been to display discrete pieces of text intact, the purpose of the final chart was to display trends

or themes that had emerged in the data. This was achieved through the use of coloured markers to notate the expression/non-expression or quality of particular themes or theme variations. In many cases the resultant graphic displays merely confirmed inferences already drawn, and in others caused me to reassess and reformulate conclusions.

Data elicited using the demographic questionnaire were compiled and displayed on a chart. This display enabled me to assess the similarities and differences of the participants in the three stages of pregnancy. Although there was no attempt to recruit research participants according to demographic characteristics, it was important to determine whether there were consistent patterned differences between research participants in each of the three stages of pregnancy (for example, if one group had been composed entirely of older women, or another group had be composed entirely of women who were the youngest in their families). If such differences had been found, they may have affected the research findings.

After all data were coded, comparisons were made between the data elicited from those research participants who had attended prenatal class and those who had not. Comparisons were also made between the research participants in early, middle and late pregnancy to determine similarities and differences in cultural transmission as pregnancy progresses. The data were further analyzed to detect any relationships that may exist between patterns of values and patterns of the social situations, or aspects of those situations, in which childbirth knowledge had been acquired. The method of data analysis employed in this study produced a rich description of the cultural transmission of childbirth knowledge among nulliparous women.

Validity

The interview guide I used had face validity in that the questions appeared to make sense and effectively elicited the information I was seeking (Brink & Wood, 1988:167). The questions that made up the interview guide had content validity in that they explored topics developed from the literature within an established theory of cultural transmission.

Validation of my interpretation of the data was not sought from the study participants primarily because all the participants had given birth by the time I completed the data analysis process. Once the women had given birth, I did not feel that they would "know" the same things about childbirth that they knew prior to giving birth. Nevertheless, I did seek validation from a nulliparous woman who had not been included in the study. She was asked to read, comment on and correct my interpretations of the data as presented in Chapter IV of this thesis.

Further validation of my findings has been sought through presentation of this research in public forums, including a seminar in the anthropology department, an address to a midwifery conference, and an address to a local childbirth organization. The response to my research has thus far been encouraging. Discussion of my findings has been ongoing with my colleagues in the department of anthropology and the faculty of nursing. I am grateful to my colleagues for pointing out the areas in which I may have misinterpreted the data, or under-emphasized certain aspects of my findings.

Reliability

The method of data collection was neither stable nor repeatable since it involved the interaction between a particular researcher and a particular research participant at a particular time and place (Brink & Wood, 1988:175). To ensure that interviewees were giving constant answers, I

incorporated alternative form questions into the interviews whenever possible. Since many of the interviews were quite lengthy, alternative form questions tended to be used more often when the question asked in its original form did not elicit a satisfactorily descriptive response.

Protection of Human Rights

Prior to beginning the data collection stage of this research project, I obtained approval for this study from the ethics committee in the Department of Anthropology at the University of Alberta. Due to the potential of recruiting research participants with low levels of literacy, I ensured that the informed consent form was scanned for readability at a grade eight level. I informed participants who expressed interest in the study of the purpose of the study, the amount of time it would entail and that they were free to withdraw from the study at any time. The participants in this study were guaranteed that their names would remain confidential, and that I would avoid incorporating any identifying details in published material (Appendix VI).

To avoid the possibility that any research participant could be identified from either the audio tape or the transcript of her interview, I assigned numbers to each participant and labelled all tapes and transcripts with that number. Any notes or papers which make reference to the identities of the participants were kept in a separate, locked file. Collected data, including tapes and transcripts of the tapes, were kept, and will be kept in a locked cabinet in my home for a minimum period of seven years. My supervisor was the only person, other than me, who had access to the raw data. I informed the participants that the raw data collected may be used for secondary analysis at a later date, but that such analysis would only commence subsequent to reviewal by an appropriate ethics committee.

The research participants were guaranteed confidentiality in any publications or presentations resulting from either primary or secondary analysis. The participants were given pseudonyms and any other identifying characteristics such as the name of their husbands, their physicians, or places of residence of their friends and families have not been revealed, and will not be revealed in any presentation of this research.

The research participants were notified through the consent form that if I suspected any of them to be victims of spousal abuse, I would discuss with them the necessity of contacting appropriate agencies. All interviewees voluntarily agreed to participate in this study under the conditions stipulated and duly signed a consent form.

CHAPTER IV - FINDINGS

Introduction

Childbirth knowledge is cultural knowledge and is part of the whole culture. The cultural transmission of childbirth knowledge is therefore the transmission of culture; one learns about childbirth as an aspect of learning one's culture. Cultural knowledge related to childbirth but which is not "childbirth knowledge" nevertheless articulates with childbirth knowledge and is part of the concept "childbirth". This cultural knowledge is acquired in the course of daily living, indeed, perhaps the bulk of what is known about childbirth is distilled from learnings acquired in other contexts and applied to the concept "childbirth." During the analysis of the data the evidence and implications of broader cultural transmission were taken into account. The interplay between the general and the specific has therefore been acknowledged, but the focus in this study remains on the specific. The cultural view of childbirth can be seen as a microcosm of broader cultural values.

This study was designed to discover the way in which twenty-four nulliparous women, living in a particular place and at a particular time, came to know what they know about childbirth. It was not designed (as some of the research participants had anticipated) to assess the levels of women's comprehension of medical facts nor to test their facility with medical terminology. That women's descriptions of birth revealed their comprehension of medical facts, and that their descriptions were often peppered with medical language, was indicative of the social sector in which childbirth is culturally categorized and valued; namely, the medical sphere. Beneath the surface of this observation lies the question of how the process of cultural transmission of childbirth knowledge works to link the category of birth to the category of medicine. The issue is raised here in order to differenti-

ate between that which is (culturally) considered to be childbirth knowledge (medical fact) and that which is considered in this research study to be childbirth knowledge (the cultural patterns which prescribe that medical facts, among other things, are what one needs to learn before one gives birth).

In this chapter the findings of this study will be presented beginning with a description of local maternity services and a description of the characteristics of the research participants. The discussion will then turn to the manner in which Dobbert's (1982) General Theory of Cultural Transmission was applied to the data to delineate several distinct patterns of cultural transmission/acquisition. Using the cultural transmission/acquisition patterns as a framework for the presentation of the findings, the remainder of the chapter will be devoted to a description the process of the cultural transmission of childbirth knowledge. The description of this patterned process will be liberally illustrated with quotations selected from the transcribed interviews. I will conclude the chapter with a summary of the findings of how and when nulliparous women come to know what they know about childbirth.

Local Maternity Services

Edmonton is the capital city of the western Canadian province of Alberta having a population of 839,924 in the metropolitan area (Statistics Canada, 1991). The city of Edmonton proper has four hospitals which offer maternity services (two at the tertiary level and two at the secondary level), with a further two primary care hospitals situated in satellite communities (Alberta Health, 1989). In addition to the maternity services provided by hospitals, Edmonton has been the home of a thriving domiciliary midwifery practice which has served both Edmonton and the surrounding rural communities since the late 1970's (Edmonton Midwifery Group,

1989). Prenatal classes are offered by all city hospitals, by the Edmonton Board of Public Health in community districts throughout the city, by Rural Boards of Public Health, by two midwifery practices, and by independent agencies. There is no out-of-pocket fee charged for enrolment in prenatal classes offered by public Boards of Health, however prenatal education programs delivered by other agencies entail fees of seventy-five to ninety dollars. The publicly financed health care insurance plan enables all pregnant women to engage the services of any private physician (either a general practitioner or an obstetrician) and it enables all pregnant women to give birth at the hospital of preference. A woman's choice of hospital limits her choice of practitioner to those physicians having admitting privileges at that hospital. Similarly, a woman's choice of physician limits her choice of hospital. If a woman chooses to give birth at home with the assistance of a midwife (as one study participant did), the cost of the midwife's services is not insured but must be paid personally.

Four research participants were not residents of city of Edmonton proper; three lived in satellite communities and one lived approximately 200 kilometres from Edmonton but had engaged a physician in Edmonton, was planning to give birth in Edmonton, and was in the process of relocating to Edmonton. All participants had equal access to any of the maternity services offered in the city, although the women living in the satellite communities availed themselves of services offered in those communities. One woman who lived in a satellite community planned to give birth in a city hospital. The other two women living in satellite communities planned to give birth in the hospitals in their respective communities. Finally, one woman planned to relocate to another city prior to giving birth and did not plan to use the services of a physician, a hospital or a prenatal class in Edmonton.

Characteristics of the Research Participants

Socio-demographic Characteristics

Demographic data were analyzed for descriptive purposes and to ascertain any marked differences between the women in the early, middle and late stages of pregnancy. Being alert to the possibility that ethnic heritage could have an effect on the cultural transmission of childbirth knowledge, I questioned the women about their background. This was not done for the purpose of making cross-cultural comparisons, rather it was a precaution taken in case there were any glaring differences found in the data. No such differences were found to exist, however.

Twenty research participants were confused by the question pertaining to ethnic background and either left it blank, indicated it was not applicable, indicated "none," indicated "white," or most often, after clarifying the intent of the question indicated "Canadian" of a particular descent (Scottish, Finnish, etc.). Only four women identified themselves as having an ethnic heritage distinct from "Canadian;" two identified themselves as Ukrainian, one as German, and one as Chinese. Twenty-one women were born in Canada, fifteen of them in Alberta, three in British Columbia, two in Ontario, and one in Manitoba. Of the remaining three women, one immigrated to Canada from Hong Kong at age three, one immigrated to Canada from Switzerland at age fifteen, and one immigrated to Canada from the United States within the past year. Nineteen women had learned English as a first language, and one each had first learned German, Swiss, Chinese, French and French and English simultaneously.

Nine women grew up in a large city, four in a small city, eight in a town or rural area, and three had lived on farms. The women's natal families ranged in size from two children to six. Sixteen women had younger siblings and eight women were youngest children. The women ranged in age from twenty-three to thirty-seven; twelve were twenty-nine or older and twelve

were twenty-eight or younger. Twenty women were married, two were living in established common-law relationships and two were single.

Eight women had attended but not completed college or university, fourteen had completed college or university, and the remaining two had completed graduate school. Six women were engaged in full-time employment, six were self-employed, four were unemployed, three were engaged in part-time employment, two were on maternity leave, one was on sick leave, one was a university student, and one had retired. Of the sixteen women who reported their occupation or their occupational training, three were teachers, two were occupational therapists, two were secretaries, and one each was a cashier, an artist, an actress, a speech therapist, a book keeper, a physiotherapist, a lawyer, a bachelor of arts graduate (social science), and an agriculturalist. Thirteen women reported their family income in the range of $0 to $40,000 per year, nine reported their family income in the range of $41,000 to $80,000+ per year, and two did not report their income.

The chart below illustrates demographic characteristics of the research participants by stage of pregnancy. Although some differences are apparent, women having similar characteristics were distributed fairly evenly across the three stages of pregnancy. Some demographic features of the Edmonton population have been displayed for comparative purposes, although only rough comparisons are possible because the Statistics Canada (1991) grouping of data differs from that in this study. Nevertheless, the research participants appear to have higher levels of education than the similar age group of females in the province; they appear to have the same household income levels as the population in Edmonton; and a higher proportion of the research participants had a first language other than English than was true of the Edmonton population.

TABLE I
Socio-Demographic Characteristics of Research Participants

	EARLY PREGNANCY	MIDDLE PREGNANCY	LATE PREGNANCY	TOTAL	DEMOGRAPHIC CHARACTERISTICS OF LOCAL POPULATION (Statistics Canada, 1991)
Recruitment					
Response to advertisements	4	7	6	17 (71%)	
Referrals	4	1	2	7 (29%)	
Age					% of City ♀ Age 20-39 with no children
23 to 25	1	1	2	4 (17%)	20-24: 88%
26 to 28	3	1	4	8 (33%)	25-29: 52%
29 to 31	2	1	1	4 (17%)	30-34: 29%
32 to 34	2	3	1	6 (25%)	35-39: 19%
35 to 37	0	2	0	2 (8%)	
Range	24-34	23-37	24-33	23-37	
Mean	28.75	29.63	29.50	29.37	
Marital Status					
Married	7	6	7	20 (83%)	
Common-law	1	0	1	2 (8%)	
Single	0	2	0	2 (8%)	
Post-Secondary Education					% of ♀ in Province Age 25-44 years with post-secondary education
Post-Graduate	1	1	0	2 (8%)	48.8%
Diploma/Degree	3	5	6	14 (58%)	
Incomplete	4	2	2	8 (33%)	
Employment Status					City ♀ Age 15+
Employed/Student	8	7	1	16 (66%)	61% Employed
Unemployed/On Leave	0	1	7	8 (33%)	
Family Income					City Household Inc
$0-$20,000	1	2	2	5 (21%)	22% (0-19,999)
$21,000-$40,000	3	1	4	8 (33%)	26% (20,000-39,999)
$41,000-$60,000	3	1	2	6 (25%)	24% (40,000-59,999)
$61,000-$80,000+	1	2	0	3 (12%)	8.5% (60,000-69,999)
Not Reported	0	2	0	2 (8%)	19.5% (70,000+)
Natal Home					
Large city	3	4	2	9 (37%)	
Small city	1	2	1	4 (17%)	
Town	3	2	3	8 (33%)	
Farm	1	0	2	3 (12%)	
Sibling Rank					
Eldest	4	2	4	10 (42%)	
Middle	1	3	2	6 (25%)	
Youngest	3	3	2	8 (33%)	
First Language					♀ & ♂ City Total Pop
English	7	6	6	19 (79%)	88%
Language other than English	1	2	2	5 (21%)	12%

The Research Participants' Stage of Pregnancy

The table below displays the distribution of the research participants' stage of pregnancy at the time of the interview, as well as displaying the pseudonym assigned to each participant. All quotations derived from the interviews and used to illustrate the text of this chapter will be identified by the women's pseudonyms and their stage of pregnancy.

TABLE II The Research Participants

EARLY PREGNANCY		MIDDLE PREGNANCY		LATE PREGNANCY	
NAME	STAGE OF PREGNANCY	NAME	STAGE OF PREGNANCY	NAME	STAGE OF PREGNANCY
Laura	5 weeks	Anna	20 weeks	Charmaine	34 weeks
Diane	8 weeks	Ellen	20 weeks	Liona	34 weeks
Kim	8 weeks	Michele	20 weeks	Donna	34 weeks
Catherine	9 weeks	Jane	21 weeks	Penny	35 weeks
Lynne	14 weeks	Vicki	22 weeks	Jackie	35 weeks
Geri	15 weeks	Janice	25 weeks	Andrea	38 weeks
Caroline	18 weeks	Becky	26 weeks	Emily	39 weeks
Käthe	19 weeks	Yvonne	27 weeks	Cheryl	40 weeks

As is indicated in the chart, I interviewed women at various stages of pregnancy ranging from five weeks to forty weeks. Two of the women were interviewed twice; Jackie was interviewed at 31 weeks and again at 35 weeks and Vicki was interviewed at 14 weeks and 22 weeks. Audio tape was collected from these women only in the second interviews, however field notes were made following the first interviews. The twenty-four interviews in which audio tape was collected were evenly distributed between women in early, middle and late pregnancy, however they were not distributed evenly over the course of pregnancy. Rather there are two clusters of over-

representation of research participants at around 20 weeks and around 34 weeks.

The dual purpose of collecting data from women in all stages of pregnancy was to ensure that the data collected were not solely reflective of the childbirth knowledge learned in prenatal classes and to discover the differences between the knowledge exhibited by women in early, middle, and late pregnancy. Underlying this sample selection are the assumptions: first, that women use the period of pregnancy to learn about childbirth; and second, that the learning time available to women post-pregnancy should affect the quality of the childbirth knowledge exhibited at the time of the interview. I should note here that when I asked the women what they knew about childbirth, I was not concerned with measuring their knowledge in any absolute sense (that is, I was not looking for the right answer), however I was concerned with comparing the data elicited from each research participant relative to the data from the other participants.

Stage of Pregnancy as an Indicator of Available Learning Time

The stage of pregnancy was determined by scrutinizing the transcripts for the women's statements indicating their current week of pregnancy. If no such statement existed, stage of pregnancy was calculated by counting back from the expected "due date" to the date of the interview. "Stage of pregnancy" is used in accordance with cultural conventions; it is an indicator of how women described themselves and would be described by their childbirth practitioners. It is not, however, a true indicator of the women's available learning time post-pregnancy but prior to the interview. Firstly, the stage of pregnancy is calculated from a time approximately two weeks prior to conception, and secondly most of the women did not become aware of their state of pregnancy until two weeks after conception. Therefore, there is a difference of four weeks between the "stage of pregnancy" and the women's

awareness of their "state of pregnancy." For the women in late pregnancy, the difference between forty weeks and thirty-six weeks, as a measure of available learning time, is negligible. For women in early pregnancy, however, the available learning time is severely reduced, for example from five weeks to one and from eight weeks to four. The actual amount of post-pregnancy learning time available to the research participants therefore ranged between one week and thirty-six weeks.

Although the emphasis in this study was placed on the acquisition of childbirth knowledge during pregnancy, there was overwhelming evidence in the data to suggest that much of what the research participants knew about childbirth was learned prior to pregnancy. There was little qualitative difference between the knowledge held by women in the early stage of pregnancy and those in the later stages. Indeed, the twenty-four women's descriptions of the physical and emotional experience of birth, the birth setting, the role of birth attendants, and the rationale for the use of intervention were remarkably consistent. That is to say that what the women in this study knew about childbirth did not appear to be affected by their stage of pregnancy. This is not to suggest that there were no differences among the twenty-four women, but it is to suggest that this could not be explained by attendance or non-attendance at prenatal classes nor could it be explained by the stage of the woman's pregnancy. The women's concepts of 'childbirth,' which appear to have been formed in the pre-pregnancy period, will be more fully discussed in the next chapter. The remainder of this chapter will be devoted to discussion of how the cultural transmission of childbirth knowledge shaped the women's concepts of childbirth both prior to and following pregnancy.

Patterns in the Cultural Transmission of Childbirth Knowledge

The research participants' descriptions of the circumstances surrounding the acquisition of discrete bits of childbirth knowledge provided ample evidence to support the conclusion that the cultural transmission of childbirth knowledge in the period prior to pregnancy was extremely important in shaping their concepts of childbirth. The women, however, rarely considered this period of knowledge acquisition to be of much significance, nor did many of them consider that any knowledge acquisition had necessarily occurred. The following quotes, chosen for their representativeness of research participants in early, middle and late pregnancy, are illustrative of this point of view:

> It was brought up a few times. But I think in the past I never really paid attention because it never concerned me. So when someone was talking about it I'd listen, but not really. Now that I'm pregnant, it's maybe, because it's concerning me I'm paying more attention. So I think it probably has come up, I've just never noticed it before [*Lynne, 14 weeks]* (page 5).

> [W]ell actually I bring up the subject more now that I'm pregnant. But before that...people had no trouble getting into the whole detail, into the whole thing. And things that they might have told me would kind of go in one ear and out the other. They kind of stick in your mind but now they all come back and then you start asking them about things...And now I ask way more questions of my sister, just every time I talk to her [*Janice, 25 weeks*] (page 4).

> Mostly since I've been pregnant, actually. I'm sure they told me before I was pregnant but it just sort of went right through me and I just didn't hear. When it applies to you, you really, you know I should have listened a little better because I'm sure I'm asking them the same questions, you know, that they've already told me when it did happen [*Andrea, 38 weeks*] (page 5).

Analysis of this type of statement yielded a crude categorization of two basic transmission/acquisition patterns: a passive pattern which occurred primarily in the period prior to pregnancy and in which there appears to be little intention to learn or teach about childbirth; and an active pattern

which occurred primarily in the period following pregnancy and in which there appears to be an intention to learn or teach about childbirth. It is much too simplistic, however, to categorize all episodes of transmission/acquisition as being either active or passive. Rather, each learning episode has several properties, not only intentionality, and therefore to adequately describe the patterns of cultural transmission/ acquisition these properties must be taken into account.

According to Dobbert's (1982) General Theory of Cultural Transmission, cultural transmission is a complex process that is non-linear, systemic and interactive. Taking this theoretical framework as the basis for analysis, the data revealed that learning episodes exist on a continuum from the most passive to the most active and often flow from one form to the other according to the interaction between the 'teacher' and the 'learner.' It is necessary to analyze the actions of both the transmitter and the learner; each act occurs in a particular setting; each act is either inclusive or exclusive of certain categories of people; and the responses of the people involved in the act, either through body language or verbal language, convey messages of behavioral appropriateness when discussion of the topic 'childbirth' arises. All acts are therefore value laden in that they inherently define the various aspects childbirth it is permissible to discuss, where the topic may be discussed and with whom it may be discussed.

The data gathered in this study are reflective of what the research participants learned about childbirth, when they learned it, and from whom it was learned. Although it is impossible to reconstruct with certainty the circumstances surrounding any particular learning episode, inferences about the acts of cultural transmission were drawn. Three forms of transmission and their corresponding forms of acquisition were identified and labelled according to the learner's ability to act or be included in an act of discussing or observing childbirth. The data were scrutinized for evidence of the

transmitter's signals which encouraged the learner to inquire further, which constrained the learner from making further enquiries, or which sent a mixed signal. The data were similarly scrutinized for evidence of the learner's signals of interest or disinterest in the subject matter.

In its most passive form, childbirth knowledge is transmitted via the content and values of a situation. During episodes of ***situational transmission*** there is no attempt to teach or learn about childbirth, rather the situation itself serves as a model for the learner. Corresponding to this form is ***observational acquisition***, the most passive form of acquisition. The learner observes the situation, including people's behaviour, activities, language and emotional responses, accepting the situation as a model and storing it away whole. As will be discussed below, the events surrounding the birth of a sibling exemplifies this form of transmission/acquisition of childbirth knowledge.

Although all learning episodes carry within them elements of the most passive forms of transmission/acquisition, a learning episode moves from being purely situational transmission to the more active form, ***conversational transmission***, when there is some direct involvement of the learner in the episode. In episodes of this type the transmitter imparts information about childbirth as a by-product of talking about life experience. This would include such examples as relaying the news of a birth in the extended family, or pointing out to a child the hospital in which she was born, and it would include stories of birth depicted in films and written about in novels. Corresponding to this form of transmission is ***opportunistic acquisition***, a more active form of acquisition in which something about the learner's observation of a situation or conversation peaks her interest and provides her with the opportunity to seek clarification. In these cases, the learner is not necessarily seeking childbirth knowledge *per se*, but may be attempting to understand how new informa-

tion about childbirth fits with what she already knows. For example, a child might seek clarification for why she was born in that particular hospital, or what it is about birth that requires hospital care. Similarly, in acts of opportunistic acquisition the learner may initiate the learning episode herself. For example, when driving by a hospital the learner may ask whether that was the hospital she was born in. If her mother replies "No," and offers no further explanation, the mother has subtly constrained the learner from asking more questions. The data gathered in this research study indicate that much of what the research participants learned about childbirth prior to pregnancy was learned via conversational transmission and opportunistic acquisition.

Finally, ***instructional transmission*** and ***purposeful acquisition*** are the most active forms and are characterized by an implicit assumption that the learner has a right to, or need for, information about childbirth. This interaction pattern usually does not occur until after the learner is seriously contemplating becoming pregnant or is pregnant. After she is pregnant, the learner will often single out one or more trusted people (mentors) who through either experience or training (preferably experience and training) know about childbirth. The mentor is often a person who during pre-pregnancy or pregnancy demonstrates her willingness to openly discuss pregnancy and childbirth, therefore the mentoring relationship is often rooted in episodes of conversational transmission and opportunistic acquisition.

This is not to suggest that only mentors are instructional transmitters. To the contrary, as soon as a woman's pregnancy becomes public knowledge any number of minor acquaintances begin to offer proscriptive and prescriptive advice in addition to delivering what several research participants labelled as "horror stories." Interestingly, in her study of Mayan childbirth practices, Jordan (1993:32) described a similar phenomenon. In this case, however, the

women who attended births related their "horror" stories during labour. In other words, these instructional transmissions occurred within the context of the specific activity (the birth event). This contrasts with the pattern of instructional transmission found in my research study. Instruction about birth takes place in social settings completely removed from the birth event. Such forms of instructional transmission may occur long before pregnancy and can be paired with the opportunistic form of acquisition. This would include episodes of teaching sexual education in formal education settings and episodes of television broadcasts of documentary films about human reproduction. Finally, although a pregnant woman may purposefully seek childbirth knowledge, all such episodes do not result in an act of instructional transmission. As is the case with conversational transmission, the transmitter's signals will either encourage open discussion or may constrain further enquiry.

Cultural Transmission of Childbirth Knowledge Prior to Pregnancy

Learning About Birth in Early Childhood

The following section demonstrates that learning about the cultural patterns and values surrounding the birth event often begins very early in a child's life. When a child's sibling is born, her first knowledge of the birth event becomes tightly woven with the values inherent in the situation: mothers (and fathers) go away when babies are born; babies are born in the hospital; doctors deliver babies; children are excluded from birth; and the birth of a baby is an exciting and joyous occasion. All of this the child learns through observation. Although a few simple explanations may perhaps be offered, there need not be any intentional teaching in order for the child to learn the cultural patterns surrounding the birth event. Like the snap-shot from a polaroid camera, an instantaneous, if fuzzy picture begins to emerge.

Each time the pattern is repeated (through the birth of new siblings, cousins, neighbour children, family pets, television portrayals, etc.), new categories are added and the picture gains increasingly more clarity.

The Birth of a Sibling

Two-thirds of the research participants indicated that they were either the eldest or the middle child in their families. Of these, five had no memory of their sibling's birth (their ages at the time of the events ranged between thirteen months and two-and-half years); three participants who very likely had conscious memories (age range four years to five years) were not asked about their memories of their siblings' births; and the remaining eight participants remembered, with varying degrees of clarity, the events surrounding the birth of a sibling.

The following descriptions of the events surrounding the birth of a sibling exemplify the observational acquisition pattern. Note the striking similarities in the women's descriptions: family or neighbours are called on to care for the older children; mother and father disappear; mother and father reappear with a new baby; the child has little or no involvement with the birth event. These descriptions have a matter-of-fact quality; a child's acceptance that this is the way birth is done.

> I remember being taken out to the park with some relatives because my dad was at the hospital with my mom. And then I remember all of a sudden, you know my dad, my dad never usually came out to the park with us, then all of a sudden he just left. He left us with the relatives or the neighbours, they were neighbours, and then we were told, I guess a little later that night that we had a baby sister. And then I remember my mom coming home a day or two after that. So the actual experience we didn't really get much information on, it was more my mom disappeared one day and came back with a baby. So there she was (laugh) [*Becky, 26 weeks pregnant*] (page 10).

> Vaguely, I do remember being pulled out of my bed, quickly dressed, I was still asleep, my dad took me to my aunt's

> place, then my uncle went with my dad and my mom in the red Charger from [Smalltown] all the way up to the city to the [Big Hospital]. That's where both my sister and I were born. And I can't remember actually seeing her for the first time, like I'm not sure if I was actually taken to the hospital or did I just have to wait until my sister was brought home? [*Kim, 8 weeks pregnant*] (page 6).

In Kim's description, the element of emergency adds a dramatic layer to her perception of what birth is about: the child was dressed "quickly," and her mother and father rode in a "red Charger...all the way up to the city." In contrast to the foregoing descriptions, Jane's description of the events surrounding her sibling's birth reveals that sometimes children were given a little more information about birth. Jane's brother had been born with the use of forceps, and because the child looked different than was expected, this fact required explanation. Although Jane's recollection of her brother's birth retains many of the patterns apparent in the foregoing descriptions, it also incorporates the elements of birth being potentially "difficult" for the woman and deforming or injurious for the child.

> I remember that my brother's ears were born, at that time we would have said maybe deformed, they were different, they were up, you know so we kind of teased him that he was like a Dumbo the elephant, and the explanation of course was that it was a little bit of a difficult birth and I think she used to say to me that maybe the ears were like that inside, and we had to put tape on them to hold them down, roll them back to where they should be. I don't know if I went up to the hospital at that time or not, I just, I do remember that I got this doll and that was to be mine and that there was a cousin that was living here and she looked after me while they were gone. [*Jane, 21 weeks pregnant*] (page 12).

Although Jane, Becky and Kim were excluded from the birth event, none of them expressed feelings of being explicitly excluded. In contrast, Janice was taken to the hospital, and interestingly, this greater degree of involvement appears to have produced heightened feelings of exclusion.

> About all I can remember about my sister, back then you were never allowed to go into hospital to visit, and I just remember my dad parking us outside the hospital and my mom would come to the window with the baby. That's all I can remember [*Janice, 25 weeks pregnant*] (page 11).

There is no way of knowing exactly what it was that Janice's father explained while he and the children waited to catch a glimpse of the new baby through the hospital window. Nevertheless, Janice learned that separation from her mother and new sibling was not merely an oversight. She learned that children were not "*allowed* to go into hospital to visit." Quite obviously, Janice's parents wished to share the event with their older children but could only do so within the limits of hospital policy. In a instant Janice learned that the hospital had the vested authority to define which social members had access to the events surrounding birth, and that her parents willingly complied with that authority.

Even for the research participants who were the youngest in their families or who were too young to remember the birth of a sibling, there were still opportunities to learn about birth at a very young age. In both the following cases, information about childbirth was acquired by listening to mothers' conversations with other women. The acts of acquisition were therefore observational; neither of the children were involved in the discussions.

> [My aunt] had a baby when I was about six years old. Like I remember just them [mother and aunt] talking and I don't know, I'd just be sitting there listening I guess. Or even when my sister had her kids, because I was younger and not even close to having kids (laugh), so I was excluded from the conversation I guess (light laugh) [*Vicki, 22 weeks pregnant*] (page 4).

> Our next door neighbour, I remember when she had her kids. I think I was about six or seven when she had the first one. It was just neat to go over and see the baby. I remember her telling mom that she'd never do it again but she did it twice more anyway. [*Penny, 35 weeks pregnant*] (page 8).

These narratives are not only retrospective, but they recollect events that occurred, in some cases, over thirty years before. It would be imprudent therefore to understand these narratives as literal descriptions of the knowledge the research participants actually acquired at the time of transmission. Possibly, or even probably, with the passing of years memories such as these were worked and re-worked each time new knowledge was acquired and fitted into the picture. The relevance of these narratives to the study is their suggestiveness that very early in life children are provided with parts of a model which feeds their ideas of the "proper" conduct of birth.

Talking to Children About Pregnancy

Pregnancy is a vivid symbol of fertility, an overt reminder of women's sexuality. Imbedded as they are in the category sexuality, it was interesting to analyze the data for evidence of when the connection between the category of sexuality and the categories of pregnancy and birth were made. There is no indication in the data to suggest that the research participants asked their pregnant mothers how the baby got inside her tummy, nor to suggest how the mothers may have reacted to such questions. Nevertheless, two of the research participants provided evidence of the way they reacted when children asked them about their pregnancies.

> Daryl's cousin is four I think, and we were over there just before Christmas and she hadn't seen me pregnant and so she asked me, "Oh, are you going to have a baby?" and I said, "yes," and she asked me something about how did it get there? and I just, I didn't know what to say, it just, you think I would have thought of something by now, but she asked her mom, her mom was standing right there, her mom took her aside, I could kind of hear something but it was, she just kind of gave her a little explanation and that was fine [*Donna, 34 weeks pregnant*] (page 21).

In her narrative Donna indicated that she was taken aback by the child's question; she "just didn't know what to say."

Donna had not prepared herself for a satisfactory euphemistic response to the question. This provided the opportunity for the mother to move in, to take her child aside, and to explain the situation to her satisfaction. Whatever the child learned about pregnancy, she also learned about the social behaviour for talking about pregnancy through the way in which the adults reacted to her question. Donna's description can be compared to the description Vicki offered of a similar scenario:

> My friend's little four year old, she was telling him that I was going to have a baby and he says "Oh, where did the baby," or "how's she having a baby," or "where did it come from?" type thing. And she had told him before that God puts the baby in Mommy's tummy and Daddy helps and so she says, "Do you remember what I told you before?" and he says "Yeah," and "Well what don't you understand?" and he says, "Well, who's the daddy?" and she says, "Well I don't know I've never met the daddy," and he says "Has Vicki ever met the daddy?" and she says [sarcastically] "Well yeah, I guess so" [*Vicki, 22 weeks pregnant*] (page 22).

In Donna's case, the child had opportunistically introduced the topic, but in Vicki's case the mother was in conversational control. Vicki's visit had provided the mother with the opportunity to re-engage in deliberate teaching about pregnancy. The mother clearly wished to teach her child about the more spiritual or cosmic elements of pregnancy. Her explanation was well prepared but faltered when the child's unexpected question threatened to uncover the physical aspects of conception. Perhaps not surprisingly, the teaching episode ended abruptly at that point.

Learning About Birth in Later Childhood and Adolescence

As children approached and passed through puberty, they were presented with more opportunities to learn the connections between sexuality and birth. Some of this learning took place through observation, when, for example, the children watched animals give birth. Research participants who were very young when they witnessed the birth of animals spoke

about "not understanding what was going on" (Lynne, page 7). Research participants who were older when they witnessed the birth of animals, or who had witnessed animal birth many times did not speak about lack of understanding. They did however speak about their aversion to body fluids, describing animal birth as being "gross" or "messy." Despite their feelings of aversion to body fluids, witnessing the birth of animals was an emotionally charged event and the research participants often described it as being "fascinating."

By the age of ten or eleven, most of the research participants received some form of sexual education, and of course in the early teenage years all the research participants experienced menstruation. This was the time they might discuss childbirth with their mothers. In late childhood and adolescence, they had reached an age where it was socially acceptable for them to learn about sexuality and childbirth and the connections between the two.

Witnessing Animals Give Birth

At some point between childhood and adolescence, approximately half of the research participants took advantage of the opportunity to watch the birth of family pets or farm animals. The remaining research participants appear to have not had the opportunity to watch animals give birth, but none of the research participants mentioned being prevented from watching birth. This implies that although children were excluded from the event of witnessing human birth, animal birth was deemed acceptable and suitable for a child's observation.

The research participants' narratives demonstrated that birth was perceived differently depending on whether the animal giving birth was a family pet (indoor animal) or a farm animal (outdoor animal). Family pets were much more likely to be ascribed human qualities: the research participants feared for the pain their pet was experiencing; frequently a special place was prepared for the birth to take place and the

children ensured that the pet stayed there; the research participants spoke about the pets needing to be comforted and supported during labour; they spoke of their need to call someone or to involve someone else (perhaps an authority figure); and finally they talked of their amazement that the animal "knew what to do." Although some of these themes occasionally appeared in the narratives of women who described the birth of farm animals, more frequently those research participants who had seen farm animals give birth described complications and the need for human intervention in the birth process.

Liona's narrative is a fairly typical description of the events surrounding the birth of family pets.

> Well I saw the puppies coming out, two times, two different dogs had puppies and my sister and I were watching the one. We had our house here and then we had a shed back here and the dog was having her puppies out in the shed in the middle of winter and we had straw all piled around and everything so she could kind of nuzzle in there. And it was funny because she came to the house, she would come to the house before she was going to give birth. And like she wanted somebody to come with her you could just tell that she wanted, because she would sit at the door and cry and scratch and you'd go out there and immediately she'd be going down the stairs and down to her little thing. So we went out with her and sat with her. And it was really neat. But we kept thinking, "Wow, we should be going back to the house to tell somebody this is happening," but she wanted us to stay and we wanted to watch. It was neat though. Yeah, it was, yeah just really neat, I mean it was a little gross [*Liona, 34 weeks pregnant*] (page 6).

Like many of the women who had witnessed the birth of family pets, Käthe's description (this time of a farm animal) incorporates a description of the pain experienced by the mother animal. Käthe, who grew up on a farm, had witnessed the birth of many animals but as her narrative reveals her most vivid memory concerns the one complicated birth which required human intervention.

> At first when I was a little girl I remember that was scary because I've seen the mother go through pain and some of them one thing that comes to mind is, the calf couldn't come out,

> wouldn't come out so they had to cut the calf in half inside the womb to get it out [*Käthe, 19 weeks pregnant*] (page 7).

Whether describing the birth of a pet or a farm animal, most of the research participants implicitly considered birth to be something the mother animal actively does; occasionally (as with Käthe's description) agency was also attributed to the baby. In contrast, Becky's narrative is atypical in that there is implicit passivity ascribed to the mother animal (in fact she barely figures in the narrative at all); the action, or work of birth is attributed to the attendants.

> Well that was at my uncle's farm, they have a cattle farm, and I've seen actually two or three calves delivered. And so two of those were uneventful, it was just, you just go out and you see this little nose peeking out at you, and they go out and they just drag it out and there's this wet calf sitting on the ground, so. It looks fairly straight forward. And then the other one, just a more complicated delivery where they had to take the cow to the vet eventually...They were kind of neat though. They come out and they have these big ears and they just kind of sit there looking around. [*Becky, 26 weeks pregnant*] (page 8).

The birth of an animal not only provided the research participants with the opportunity to witness birth, but occasionally it also stimulated the children to ask questions about birth and provided their mothers with the opportunity to impart values about birth. Two of the research participants attributed the development of their present attitudes to their experiences with animal birth.

> It was just my mom and I and she just said, "You know, she'll be fine." I was a little bit worried that it might hurt Sheeba and you know she wouldn't be O.K...You know, it was just a happy, happy time. So I probably, maybe transfer that a bit to myself that it's going to be a really happy time and you know nothing will really go wrong. Might have been different if something had happened, you know gone wrong, then I might feel differently about it. But yeah definitely. Animals always been a big influence in my life [*Catherine, 9 weeks pregnant*] (page 9).

> I remember with the kittens, asking Mom, "When are they going to come? When are they going to come?" "She'll have them when she has them." I think women should probably feel that way

> about their pregnancy too [rather than having an induction] [*Charmaine, 34 weeks pregnant*] (page 11).

Whereas Catherine and Charmaine categorized animal birth in terms of the similarity to human birth, other research participants either implicitly or explicitly categorized the two forms of birth in terms of their differences. Penny's narrative clearly illustrates the distinction between birth as it is experienced by humans, farm animals and family pets. In Penny's categorization scheme, both humans and pets experience pain, whereas farm animals do not; both pets and farm animals tend to have quick labours, whereas for humans the labour process is much longer.

> It's pretty different I think than a human birth. It happens a lot more quickly and the animals don't show much sign of pain which I think is the big difference. You can put a cow through an awful lot and she doesn't really show a lot of sign of pain. They may grunt a little but that's the extent of it. Their labours are a lot faster than ours. If you had a cow that was in labour for thirty-six hours you'd have a real problem. And I've watched this little monster over here have kittens. Actually I felt very sorry for her. She was in pain. Then again it happened very quickly. I went to do laundry at nine o'clock and her water had broken in the laundry hamper and by noon we had four little kittens [*Penny, 35 weeks pregnant*] (page 7).

Learning About Sexuality in Formal Education Settings

The research participants in this study lived through an era in which it became permissible, if controversial, to teach children about sexuality in formal education settings. Although there was some difference between the styles of sexual education classes, several themes emerged from the data which add insight into the ways sexuality and childbirth are taught and discussed. The research participants tended to contrast their own experiences "back then" with the (assumed) experiences of contemporary children in which a more modern and enlightened view enables frank and open discussion of sexuality. In the following descriptions, Geri and Michele note the lack of substance in their sexual education classes;

Geri's description is typical of those research participants who attributed this lack of substance to the unenlightened era in which they lived whereas Michele's description is typical of those research participants who attributed lack of substance to the type of school (whether public or separate) they attended.

> We had a little booklet about the birds and the bees, you know, it's nothing like it is today. You know, like, it was all hush, hush and mostly learning from your friends and yourself [*Geri, 15 weeks pregnant*] (page 7).

> Well I went to Catholic schools, the only sex education class I recall having was one on menstruation. I don't recall having any, any kind of sex education course that dealt with childbirth other than in a very biological way [*Michele, 20 weeks pregnant*] (page 4).

Michele's narrative contains a second theme which emerged from the data. The open discussion of sexuality often involved a sanitizing of the issue by removing it from human emotional experience and reformulating it within a scientific framework. This theme is repeated in Catherine's, Jackie's and Cheryl's accounts.

> I don't remember a lot about, we probably learned more of the anatomy and the physiology involved and not very much about sort of the human side of, if you can call it that, so maybe that's why I sort of, learned the medical knowledge but don't remember it a whole lot because there wasn't a lot of emotion involved [*Catherine, 9 weeks pregnant*] (page 7).

> By then, thirteen, fourteen, you'd learned in health what was going on and you were having your period already so you knew what was going on there too. You know where the little books that they give you in school, and so you knew what was happening. Boy's anatomy and the girl's anatomy and just why it's like that. Nothing great detail, you know, all the words, you know [*Jackie, 35 weeks pregnant*] (page 10).

> I think the first time I ever saw it, or can remember seeing it was grade 13 Phys Ed. And it was the one that actually shows the conception (inaudible), it shows the conception and it shows everything right up to the birth...I can remember thinking, "Wow that's really neat." Just the fact that they were able to show the conception, how did they do that? It was really interesting. And the impact was just, "Oh so this is how it works" [*Cheryl, 40 weeks pregnant*] (page 7).

In both Michele's and Catherine's narratives there is a sense that there is more to sexuality than can be accommodated by purely scientific or biological description, whereas for both Jackie and Cheryl abstract scientific concepts provide the framework for the interpretation of human experience. But even if sanitation of the issue enabled open discussion, there were limits placed around how open one could be when discussing sexuality. The subject matter was apparently of such a sensitive nature that according to most research participants it required segregation of the sexes, and as the following narrative illustrates, it required "drawing the blinds."

> My sex education class in comparison to what they have now was nothing. My sex ed class was actually in grade five, the girls were in one room with the blinds drawn, we watched one film, the boys were in their room with the drapes drawn and they watched their film. And it got me so scared that I thought that as soon as I menstruate I'm pregnant...I was twelve and I was just dying...My mom thought it was hilarious. But the thing of it is though, I think it's just the way it was delivered. I mean, what's so, why is it so hush hush? Now it isn't...I mean, it is a scary part of your life, you are developing, you're getting into adolescence, body is changing, that's enough pressure. And then they put this on top of it and you don't know which way you're going...So after my mom chatted with me, and we went and bought my first box of Kotex pads, the whole thing, I felt a lot better. We even went to the library and got some books. Because my mom was quite well read. So I felt a lot better. Then my friends would come and ask me. So I was the authority on things and I thought my mom was so cool. [*Kim, 8 weeks pregnant*] (page 9).

As the foregoing narrative illustrates, Kim was highly critical of the way information was delivered in her sexual education class. She implicitly recognized the incongruity of the imposition of a veil of secrecy over a subject matter that was after all presented in public. Perhaps not surprisingly, one of the lessons she learned from sexual education classes is that books and films are authoritative sources from which to obtain accurate [i.e. scientific] information about sexuality. For Kim, this message was reinforced when her

mother took her to the library, and thereafter Kim became an "authority" on the issue in her friends' eyes.

It is difficult to know the degree to which Kim misinterpreted the information delivered in her sexual education class; perhaps the intent was to scare the children so that they would not engage in sexual activity. Where there is little doubt that Kim applied the information she learned in sex education class to herself, other research participants found their sexual education classes to be both embarrassingly uncomfortable and either irrelevant or not applicable to themselves. They appear to have already internalized the message that sexuality, pregnancy and birth were not suitable topics for children, nor for public discussion. In response to the public discussion of such a sensitive issue, the children engaged in joking behaviour and thereby maintained distance between themselves and the subject matter.

> Well you're what, how old are you then, fifteen years old, grade nine, yes, you're about fifteen years old. You're in a room with boys and girls right. Everybody's hitting puberty and you have this basically birthing film and I, well, it grossed me out. I thought, "Oh gosh." Because I'm not a blood and guts (laugh) kind of person either, and you just see this baby come out. And in fact, I remember, I just turned my head I didn't want to, I didn't really want to watch, wasn't ready to watch I guess...I think we teased each other about it, you know, because my friends knew what a weak stomach I had, you know and I think it was more of we were, I don't know, trying to get comfortable about it, teasing each other, and we didn't really take it too seriously. We were never having children anyway. Our moms had kids not us sort of thing. We weren't too serious about it at all, it was just a film in Family Life and we wanted to see somebody faint sort of thing [*Emily, 39 weeks pregnant*] (page 10).

Sexual education class may have been embarrassing, but the research participants did not question the appropriateness of teaching children about sexuality in a public forum. During these information sessions the content of the information helped to shape the research participants' concepts of sexuality, but the method of information delivery was equally important in conveying messages about the cultural concept of

sexuality. Some of the research participants described having been talked to by the teacher or the school nurse, but most often they disparagingly described that information was delivered through "little" books, or through films. The subject matter therefore, was sanitized not only through the use of a scientific framework, it was further removed from human experience through having objects rather than people deliver the information. Of course, it is not unusual in the school setting for objects such as books and films to be used as teaching tools, but one can scarcely imagine the use of books and films to replace verbal explanation in such subjects as mathematics and social studies.

The children may have been embarrassed, they may have sneered at the "little" books and films, and they may have been critical of the way the material was delivered, but they nevertheless accepted and agreed with the incorporation of sexual education into the school curriculum. But while the public discussion of childbirth was found to be appropriate within the confines of sexual education class, it was found to be inappropriate in the following atypical case, when the discussion of childbirth spilled over into another class.

> And then we had one teacher...he was our math teacher, and his wife had a baby and he spent several classes telling us about the delivery, and it's like, "O.K. I can see you're excited about this." So I remember that because that was about in grade eight or nine. He just, he was really thrilled by it all and he just shared this with every class, I think, for three or four days after the delivery...He described it in minute detail. I can't remember all the details at this point, but I just remember, he would talk for the entire class about the delivery and how things went and you know, how excited he was about it and how everything went...It was kind of all these grade eight kids looking and going, "Do you really want us to know that about your wife?" So, but it was interesting to hear that from him [*Becky, 26 weeks*] (page 9).

Becky's mathematics teacher seemed to be so thrilled with the birth of his child that he could not stop talking about it. This is a form a conversational transmission; it is the teacher's need to tell the story, rather than the students'

need to know about childbirth that motivated the transmission. This contrasts with the pattern of cultural transmission characteristic of sexual education classes. Teaching about sexuality and childbirth in sexual education classes was a form of instructional cultural transmission; there was an implicit assumption on the part of the transmitter that children had a need for this information.

Learning About Childbirth From the Mother

With only a few exceptions, the research participants indicated that at some point prior to pregnancy they had discussed birth with their mothers. Whether these discussions had transpired prior to pregnancy or after pregnancy, much of what their mothers revealed about birth was fragmentary. Mothers very often limited their discussion to such matters as the length of her labours, the weight of the child, that she had been induced, or that the child was breech. Although the mothers usually did not give their daughters detailed descriptions of their birth experiences, what they did say often seemed to be intended to provide reassurance to their daughters. Both the mothers and the daughters tended to emphasize the extent to which childbirth practice had changed in the intervening years. In contrast to themselves the research participants saw their mothers as having been young, having been uneducated about birth, and having been unsupported by her husband or significant other during labour and birth. In other instances the research participants' mothers commented on the improvements in childbirth practice such as preventing the prolongation of pregnancy or labour (i.e. a sanctioning of induction and augmentation of labour). Other research participants either knew or assumed that their mothers had been heavily medicated during labour and/or birth.

Although there were a variety of cultural transmission patterns when mothers and daughters discussed birth, the discrete incidents of transmission have in common that the

subject of childbirth was directly addressed and that the daughters were included in the discussion. This contrasts with the learning through observation that took place with the birth of a sibling, and it contrasts with the learning that took place when the daughters listened to their mothers' conversations with others.

Many of the research participants could remember only one or two discrete incidents where they had discussed birth with their mothers. Anna indicated that she had never discussed her mother's birth experiences with her, but as her narrative illustrates, the birth of a baby in the extended family provided the impetus for discussion of birth.

> My aunt had three caesareans. And, so that's where I found out about caesareans actually. That was a number, oh, that was, oh seventeen years ago. And I remember, well I was of course very young, ten years old. I remember when she had the baby, and then of course she delivered, had her baby in [another city]. So they called and told us, but they said she had had to have a caesarean section because her pelvis I believe just wouldn't go wide enough to deliver the baby. So she had to have a caesarean section. And then she had to have the rest of her children like that too. [*Anna, 20 weeks pregnant*] (page 17).

Anna went on to relate that her aunt's birth was the topic of discussion that evening during dinner. In this act of conversational transmission there is no sense of any deliberate teaching taking place. Yet at ten years old, Anna had still learned something about birth: the remedy for a pelvis that will not "go wide enough" is caesarean section, not just for that birth but for all successive births. In this account, there is no sense of alternative causes or alternative solutions; Anna's aunt *had to* have her children by caesarean section. Similarly, when Charmaine was ten years old, she learned from her mother about things that *had* to be done during birth.

> I asked about it. And basically my question was, "Does it really hurt that much?" And I remember my mother telling me about her getting cut, and ripping, and me thinking, "Oh God, what do you mean ripping? RIPPING?" She's just, "Yeah,

> ripping; they have to cut you." And that probably was, it was a long time ago...I think I was probably ten, maybe twelve when she told me that story. That's quite probably the first thoughts about pregnancy I've ever had is RIPPING. The fear of God. How do you push something that large out? It doesn't sound like it's going to be comfortable [*Charmaine, 34 weeks*] (page 5).

Although both Charmaine and Anna learned about surgical procedures that *had* to be done, and although they both learned about these features of birth from their mothers, there was a difference in the dynamic of the pattern of conversational transmission. Whereas Anna's mother volunteered information, Charmaine's mother appears to have been reluctant to talk about birth. As Charmaine recalled:

> Anybody that I have talked to in the past, before I got pregnant, they basically told me the same thing. They were around my mother's age and said the same thing my mother said, "I don't remember it. I don't remember what happened."
> *Laurie: Would they have told you without you asking?*
> Oh no (page 5).

Charmaine's account is similar to that of several of the research participants; their mothers were either unable or unwilling to answer their questions about birth, often saying that they could not remember. Charmaine disapprovingly attributed her mother's memory loss to the excessive use of drugs, and described her mother as having been "out of it." When reading Charmaine's narrative, one gets the sense that the little information that Charmaine did elicit from her mother came only as a result of her persistent questions. Charmaine, in fact, was curious enough about birth to ask not only her mother, but her mother's friends as well. The constraining response she received did not encourage her to inquire further.

In contrast, Catherine's mother tended to discuss birth frequently in the years when Catherine was growing up. Sometimes Catherine's father and brother would be present when these discussions took place, although they seldom participated in the conversations. At other times, Catherine and her

mother would be alone, engaged in a common activity. As far as Catherine could recall, she and her mother drifted into discussion of the topic; no special stimulus appeared to be required to incorporate birth talk into everyday discourse.

> I know mostly about me, you know, she told me about when I was born. And that I was a breech baby and they kept trying to turn me around and I was difficult to get out (laugh). But other than that not really, no, not in detail. She's told me so many times, yeah just casually you know. We travelled a lot as a family in the car and they just sort of came up various instances, in the kitchen, travelling in the car, I don't know probably just one topic went into another....So no, not about labour and delivery. I don't think [my father] was in the room when my mom was in labour and I was born, or my brother [*Catherine, 9 weeks pregnant*] (page).

Catherine knew that her mother had experienced a "difficult" birth, yet she indicated that her mother provided no "details" about labour and delivery, including the 'detail' about whether or not her father had attended the births. Nevertheless, Catherine's mother had demonstrated through her actions that she was willing to talk about childbirth and one senses that she would be willing to provide the 'details' if Catherine were to express an interest in hearing them. For many of the research participants, it was only after they became pregnant that they began to express an interest in hearing the 'details' of their mothers' birth experiences, and it was at this time that their mothers provided them with fragmentary accounts of their births.

Like Catherine, Caroline remembers her mother discussing birth very frequently during her childhood and adolescence, but as Caroline perceives it, her mother deliberately related her birth stories so that Caroline could learn from them. In Caroline's case there is a sense of intentional teaching.

> The first thing is, I think when I was really young, when I would hear things like "It's awful, it's painful, it's terrible, however all that disappears the moment you have this child in your arms, and then it's all worth it." Those are the kinds of things I think I could get out of the information she was giving me. That seemed to be the point [*Caroline, 18 weeks*] (page 6).

If Caroline's recounting of her mother's account had ended at this point, it would typify both the brevity and the content characteristic of many of the research participants' descriptions of their mothers' accounts. The research participants fairly consistently described these accounts to contain the messages that the birth process was the means to an end, or something a woman has to "get through" so as to hold the baby in her arms. The product (baby) was seen as "wonderful," but the process (labour and birth) was often described as "horrible," "terrible" and "painful." The "wonderful" qualities of the product were described as producing instant amnesia and the process itself was described as being "forgotten."

The continuation of Caroline's narrative is very unusual in that her mother described in detail what it was like for her to experience birth. Seldom were any of the other research participants exposed to such a detailed description from any source.

> Part of her telling me was...I think to inform me that I could take responsibility in the situation and have certain rights, and I could ask for, demand them and get them...[T]he first experience was that of being in labour and sitting in a hallway on a gurney, and basically just being left there...And with her first child a doctor came with his little goslings in tow, little interns, and they all walked up to her and took her wrist and picked it up and looked at the name on it and said, "Mrs. Seton." "Yes." "I'm doctor so-and-so, lift up your legs, spread your legs." And they all took turns giving her an internal examination, and said "Feel the contraction, this is how a contraction feels." So she was a study case. Her feelings at that time were extreme humiliation, fear, pain... She talked about the nurse talking to her as though she were a child, and telling her not to be a baby...She said that her first feeling she would have given anything for somebody else to do this thing, and I think she was fighting it...she wanted it to be over, she wanted it not to be happening and there was a lot of fear and a lot of pain, and not knowing what's going on. And...there wasn't somebody that she knew. Strange people telling her what to do and...her feeling was it was all happening *to* her. And she said there was a point in there where...it finally dawned on her that she was the only one who could do this and nobody could help her. That was her feeling of it. That she was alone, and finally took in...that "I'm

> the only one who can do this. Nobody can do it for me." And that's the point where she got down to business in terms of doing what she had to do. And what I gathered from her is that...coming to that awareness was something out of that whole birth that she could hold on to that meant the most to her. And that was the point where she had an active part in this birth and that was her accomplishment. It wasn't now happening ***to*** her...So that was...my first birth story that I ever heard [*Caroline, 18 weeks pregnant*] (page 6).

This is the type of birth story that has continued to fuel the childbirth debate; it is the type of description that some defensive model childbirth advocates would argue typifies women's childbirth experience. And yet Caroline's description of her mother's birth experience is atypical of those described by the women in this study; only one other research participant's account of her mother's experience was somewhat similar. If any of the other mothers felt "humiliated" or came to the realization that birth was their "accomplishment," they either did not relate it to their daughters or if they did, their daughters did not relate it to me.

Whereas Caroline learned about the specific details of her mother's birth experiences, Penny was provided with numerous opportunities to learn about the general aspects of childbirth through listening to her mothers' reports of her work day. Penny's mother, who trained as a midwife and worked on a labour and delivery ward, is the only mother who came into contact with birth on a daily basis. Her mother's talk about birth was so frequent that Penny was unable to separate what she had learned from her mother into discrete incidents. She nevertheless perceived that listening to her mother had provided her with a very broad knowledge base and an outlook on birth that differed from that of other nulliparous women.

> Well my mom is kind of one of these down to earth people, she's a midwife, she's seen hundreds and hundreds of babies come into the world so, she doesn't get really emotional about the whole thing. She always reassures me it wasn't that bad, and that it's really wonderful at the end. She'll just come home from work and say "You know we had the neatest delivery today..." I think I've grown up being more informed about

> childbirth than most people because my mom's so involved in it [*Penny, 35 weeks pregnant*] (pages 3 & 18).

Like Penny's mother, three other research participants' mothers were nurses, one of whom was an obstetrical nurse (although she no longer practised after her children were born). The mothers' occupational training alone did not predispose them to discuss birth more frequently or more thoroughly with their daughters than was the case with the other research participants, however the daughters of nurses appeared to value their mothers' knowledge more highly than tended to be the case with the research participants whose mothers were not trained in the health care field. This finding was true of other sources of childbirth knowledge as well: people who carried professional credentials in health care disciplines were highly valued sources of childbirth knowledge (whether or not those credentials were related to 'childbirth').

One of the themes to repeatedly emerge from the data concerned the inapplicability of their mothers' experiences to their own formulations of concrete expectations of contemporary childbirth. Because their mothers' birth experiences were very far removed in time, only rarely did the research participants consider that their mothers either had given them or could give them an adequate description of the experience of childbirth. Janice was reluctant to talk to her mother about childbirth, and instead relied on her sister or women in her peer group to provide her with the 'details.'

> [My mother] doesn't talk about it a lot. I don't find that many older women do but all the ones in my age group they like to make sure to tell you every detail (chuckle). And I'm not sure why it is that they, I don't know...I could ask her questions, but I guess also I would say times have changed a bit too. Now it's becoming, anyway you can have your husband in there and actually now I hear you can have other family members in there if you want and back then I think our mothers didn't know as much about what was going on they just kind of went in and the doctor took over and I think they actually, I get the impression that a lot of them too back then would be

> on morphine medication and would be more out of it when they're having it. Because I've asked my sister about that too. And she kind of thinks they were a little more on a lot of medication where they weren't aware as much [*Janice, 25 weeks pregnant*] (page 12).

Janice not only perceived that her mother was unwilling to talk about childbirth, but she also implied that knowing her mother's birth experience would not necessarily be helpful. Janice contrasted herself to women her mother's age. She saw herself as an educated agent who could make choices within the liberalized limits set by hospital policy; she did not see herself as a patient who allows the doctor to take over. Interestingly, Becky held the same assumptions about her mother's experience of birth. A post-pregnancy conversation with her mother, however, challenged this assumption.

> I can talk more closely to my sister, although something [my mother] said the other day surprised me...I had just been to the class where they outlined all the stages of delivery and I was telling her "Gee I don't know if I can do this," you know, and she's going, "Well, she says, "we all get through it." And I said "Well, but back when you were giving birth they used a lot of drugs." And she said, "No, I didn't use a lot of drugs." And that kind of surprised me because I just had this impression that back in the fifties and sixties they just drugged all the women to the hilt and let them have their babies in a comfortable state. But she said, "No," she didn't have that medication. So that was just on the phone, she's, like I say, in [another city] so I'll have to talk to her a little bit more when I go down to see her and find out. Because I guess I just made assumptions about what she went through. I mean I know my dad wasn't there. But I just assumed that they had done it that way. But, so I was kind of surprised to hear that they hadn't [*Becky, 26 weeks*] (page 5).

From Becky's description, it is evident that her mother did not take the opportunity provided by the conversation to volunteer any information about her experience of childbirth. Instead she provided Becky with reassurance, telling her that "we all get through it." But Becky challenged her mother on this point; she did not ask her mother, but rather told her mother that she got "through it" with the help of drugs. In other words, Becky applied the general knowledge she held of

women her mother's age to the specific case, her mother, even though Becky did not know specifically about her mother's birth experiences. Becky's erroneous suggestion forced her mother to divulge a detail of her birth experience. This stimulated Becky's curiosity; subsequently Becky considered her mother's experience to be relevant and potentially helpful.

Learning about Childbirth in Later Adolescence and Adulthood

Once the research participants had reached the stage of late adolescence and early adulthood they were increasingly exposed to birth through social contact with women of childbearing age, including aunts, sisters, sisters-in-law, friends, neighbours and co-workers. Women in their peer groups who had experienced pregnancy and childbirth frequently incorporated birth talk into their conversations, and although such conversations were a major source of information about childbirth, the research participants claimed they rarely paid attention to what was said. Nevertheless, these discussions raised the research participants' awareness of the wide variation in how women experience childbirth, but most importantly, their awareness of these variations inhibited the research participants from drawing definitive conclusions about what childbirth is like. Throughout the interviews the research participants insisted that the experience of childbirth was something of an enigma. The frequent refrain "everybody's different" suggested that the research participants resisted conceptualizing what childbirth would be like for them.

> Everybody's experience is different, what they experienced may not necessarily be what I experience and what they are able to handle or the way they handle things is maybe not the same way that I would either, like maybe they might be stronger or I might be stronger or whatever. Everybody's usually at different hospitals as well and different things happen too, and some people were pleased and some people aren't [*Emily, 38 weeks pregnant*] (page 5).

> So I'm realizing that whatever I've learned from everyone isn't necessarily going to be the same for me. And I'm learning that as I'm going along, so that's why I'm taking everyone's input, and putting it in my head, and I'm taking my own conclusions. Because I find that I'm different from everyone else. Like I'm not saying I'm special different, I'm just saying everyone's different. And I think nobody knows myself better than I do. So I know what's right for me and what's wrong for me. I take all this advice and I put it in with what I know and then that's where I draw my conclusions [*Lynne, 14 weeks pregnant*] (page 10).

The childbirth knowledge gleaned from conversations with peers was further clarified through observations of depictions of birth scenes in the popular media. The medium of television particularly, provided tangible evidence of the appearance and sound of the birth setting, the actions of labouring women, the actions of birth attendants, and the emotionally charged atmosphere that surrounds the birth event. In giving the research participants vicarious access to the birth chamber, television portrayals helped the research participants to interpret the birth stories they had heard. Similarly, the birth stories circulating among their peers helped the women to interpret and evaluate the accuracy of the television portrayals.

Learning About Childbirth from Peers

When the research participants described the possibilities that could occur during the birth process, they illustrated their descriptions by citing numerous birth stories that had been told to them by their families and friends. While acknowledging the possibilities, the research participants nevertheless made broad distinctions between what was possible and what was probable. For example, several of the research participants treated the length or difficulty of a labour experienced by a close family member (either the mother or a sister) as if it were an inherited characteristic which could be used as a probability indicator for the length or difficulty of her own upcoming labour. When formulating

concepts about the birth setting or the role and actions of birth attendants, the research participants were more likely to rely on the reported experiences of their peers. This is partly because their peers were more likely to relate the "details" of their birth experiences, and partly because the research participants tended to consider recent birth stories to be more descriptive of the current methods of childbirth practice and therefore more relevant to the formulation of their own concepts of birth. The tendency to discount older birth stories appeared to be based on the perception that childbirth practice has continually become more progressive, more liberal and more enlightened.

If a great deal of time had passed between the occurrence of a birth and the occurrence of the research participant's own pregnancy, the research participant often attributed a "bad" experience to the woman's young age and/or lack of education about birth. The research participants were sympathetic to these stories, but because they did not consider themselves to "young" or "uneducated," they discounted the possibility of experiencing birth under similar circumstances.

> Yeah, my sister had three babies, the first one was, she was so tense and so young and so uninformed, she really was not prepared for, she was such a nervous, nervous person, she wasn't prepared for what she went through. And then on top of it all the baby was breech. So we were living in a small town, they had to airvac her into the city and perform an emergency caesarean. So her first experience was not a good one [*Jackie, 35 weeks pregnant*] (page 5).

> Well, her first one [my twin sister] was only twenty and she went through some really tough times. She just didn't know, they were very, very young and she had Luke when she was twenty and the whole thing was just a really, eventually she had him by caesarean, so she didn't go through the birth thing, she went through a lot of labour with him, and a lot of pain, and being that young, and both of them being so young and it was really tough on them. They had a hard time with it and, but they managed, he's almost thirteen now, (laugh) [*Geri, 15 weeks pregnant*] (page 4).

> When [my aunt] had the second one, I was there the whole time really. I took her to the hospital, stayed with her, was there the day of her surgery, I was one of the first people to hold the baby and everything. So I was around quite a bit...I mean she just seemed like my mother did when she had her hysterectomy, no different, drugged out of her tree. She had no idea where she was, who she was, what she was doing. It was two days before she even seemed to have any, "Oh, a baby," kind of thing. I can't even imagine that happening to me. I just don't want that, really don't want that...And she just totally accepted it. I mean she didn't even think twice about it. She's not very educated. That might be the reason. She's only had grade eight education. And maybe that's why she just didn't question at all. I don't think she knew any better [*Charmaine, 34 weeks pregnant*] (page 12).

Charmaine's account demonstrates a slightly different pattern of cultural transmission from either Jackie's or Geri's. Although all three women learned much about the circumstances of these births through conversational transmission, Charmaine also learned about childbirth through her observation of the events as they unfolded in the hospital. Having this kind of access to birth was unusual, but as the following narratives illustrate, it was not unique.

> Well my one sister, I was outside the door when she was delivering. So I heard everything (snicker)...[I heard] that she was in pain, that she was in a lot of pain. I've never heard her sound like that before...I wouldn't go in (laughter), the door was open and there was just a curtain across that was, she was having her first child, that's my older sister, and me and my mom and my other sister were all outside the door and we heard everything (laughter) [*Laura, 5 weeks pregnant*] (page 4).

> I have another friend who I was almost at the birth of her son...I knew she was in labour so I went up to the hospital and I saw her. You know all throughout the day I would go and come home, go and come home...[A]nd things weren't progressing that well so they had to take her into the city to deliver so I went and her husband went and another friend of ours went. And then we waited and waited and waited, you know to find out how things were going. And they let us see her every once in a while, and she said to me one time when she was on the bed "Don't ever do this, you don't ever want to do this. This is a horrible thing you don't ever want to do it." And she eventually had to have a c-section. So then after the baby was born, and she was kind of coming out of the anaesthetic they said, "Would you like to see your baby boy?" She said,

> "No I don't want to see him," she just turned over and went back to sleep. But she doesn't remember saying that...And then everything that she says now is like, "The first doctor was bad, bad, bad because he made me have a caesarean and you know that's not the way it should have happened." I, well I personally don't like it because her doctor is a very good friend of my family. Like the first doctor. So I don't, I just kind of tune her out when she talks like that [*Liona, 34 weeks pregnant*] (page 6).

There were only three research participants in this study who had actually been in the presence of a woman who was in labour. Occasionally, however, the research participants were given very fresh accounts of the experience of birth when they visited friends or family members in the hospital shortly after a birth had occurred.

> And then a friend of mine, I went into see her just after she had her baby and I'm a year older than her so I guess I was about 20 at the time, she was 19 and she said, "I'll never have a baby," she couldn't move, "I'm never doing this again." She was so much in pain and that. And I guess that kind of had an impact too [*Ellen, 20 weeks pregnant*] (page 12).

> Another friend that had a child and what she mentioned is, I don't know if the baby was not coming out right or how that worked or if the baby was turned wrong, but all she said was he had to be pulled out with forceps. And it just left little marks on his head for a little bit. They went away right away. One reason I asked about that is that when the baby was born I asked what the little marks were and she said that's from the forceps and she had to have help pulling the baby out. They had to use the forceps. And that's all that we talked about. We never said why, how, how they worked, were they beneficial or anything. So I actually inquired about that through the little markings [*Lynne, 14 weeks pregnant*] (page 13).

Even though the research participants visited women in the hospital shortly after birth, it was not inevitable that they would be given an account of what the experience of birth was like, nor was it inevitable that the research participant would express an interest in knowing about the experience.

> I mean you go to see someone in the hospital and you look at their baby and "Oh that's a cute baby," and you know. And you don't really think about how it got there and how was labour? and all that you just, I don't know why, it doesn't really, to

> me anyway, I didn't really think about what she had gone through until I found out I was pregnant...And then all of a sudden I thought, "Gee, she's been through this a couple of times"...and all of a sudden you have all these questions and you're curious, and you think, "How come I never thought of this before?" I was more focused on the baby than on what she went through. And then I guess you realize that you're going to be going through something that she's already gone through, and you want to find out what it was like [*Catherine, 9 weeks pregnant*] (page 3).

Sometimes, women who had given birth felt compelled to share their experiences with their families and friends even though the audience was not necessarily interested in hearing about all the 'details.'

> It was actually a family discussion because that's what [my aunt] had decided, that she was going to have this home birth. And everybody wasn't quite sure about this...But my aunt is very, is really into holistic medicine, like to the point of not even seeing a doctor, whereas I still believe in, you know the medical practice...So we sort of didn't, you know, sort of, "Well whatever, if that's what she would like to do." Because she said, she had some odd, what we would think of as odd ideas, right? So, she told us that she was going to have, that she was going to give birth at home. And then when she did...she was showing us all these pictures of her and the midwife, and I think there were a couple of midwives there, and her husband, and the living room. That's where she gave birth was in sort of this living room area in their home. So, and that's how, it was all, she's just very open about that when she came, you know. She had the pictures so of course the conversation started from the pictures. You know, some people could look at the pictures and some people couldn't (laugh) [*Anna, 20 weeks pregnant*] (page 11).

> Oh I have a friend who probably had the world's worst labour. So she's told me about that in great detail, which I didn't really want to hear...She was really unprepared for the way things happened I think. She was induced and she had contractions one on top of the other and they gave her an epidural and it didn't work. And then the doctor didn't get there and the only person that was there was a student intern who didn't know what he was doing. She ripped right back to her anus and so she thinks that childbirth is the worst experience that's ever been. But hopefully it won't work out that way for her again [*Penny, 35 weeks pregnant*] (page 5).

For other research participants, the discussion of their peers' birth experiences became an inevitable part daily

living. This was not because the research participants were necessarily interested in learning about birth *per se*, but, as Caroline pointed out, because the event of birth was "so much a part of her life at that time."

> The information I heard from a couple of them was before I got pregnant, or one anyway, but that's because she's a very close friend of mine and...Now since I've been pregnant, then we've talked in more detail about certain things. But she was quite, she talked quite a lot about the experience for her, before I was pregnant, the experience. The birth, and, yeah, and that was a combination of my asking questions and her volunteering information because we were actually talking about that. And it seemed to me to be an important...it was so much a part of her life at that time, just having had the experience and needing to talk to people, to share that, wanting to [*Caroline, 18 weeks pregnant*] (page 7).

> Oh yes, at work they talk about it. There'd be different women at work, it would seem to, if somebody was having a baby people would always be telling them things. I have a friend who lives in [another city] and she comes to visit, and she went through and described the whole thing when she had her sons. I've heard, oh my neighbour when she had her daughter she explained the whole thing from top to bottom. Actually they went into great detail (chuckle). It's funny because it was years ago and now for me to remember all the detail I would have forgotten a lot of it...I never would have known about that mucus plug that comes out and I know that through them. And then the one neighbour, she had back labour where the baby was pushing and so that was quite different. And so this other lady I work with, she had gone through it for three days and she was just worn out by the time, that kind of thing. And, they all talked about episiotomies and some take medication some don't. And they all try to describe the types of pain you get during contractions, different things like that [*Janice, 25 weeks pregnant*] (page 4).

Other research participants were very curious about pregnancy and childbirth, and the experiences of their peers not only stimulated their curiosity but it provided them with the opportunity to ask questions.

> I've always been intrigued by it, by pregnancy, so whenever my girl friends were pregnant I would just bombard them with questions and they loved it. I would do the reading for them and they would ask me or we would both go to the library. Or whenever they came back from their, not the childbearing classes, prenatal classes I'd be just so, "What did you do? What did you talk about?" [*Kim, 8 weeks pregnant*] (Page 11).

> Oh well for myself, I just, it's my own curiosity. Like I just say "Tell me what it's like?" And I make them tell me what it's like because I want to know what it's like. So I'll just be, like my girlfriend Denise had a baby just last year and just after I talked to her after she had the baby it wasn't too long afterwards I just said, "O.K., O.K. tell me what it's like. What is it like?" [*Laura, 5 weeks pregnant*] (page 3).

When one of their peers did have a baby, it provided the research participants with a small window of opportunity to learn about birth. As has been discussed, sometimes the research participants were willing to explore the subject further, and sometimes they were not. But whether or not they had been willing listeners, once they were pregnant, the research participants reflected back on the conversations they had had in the past and often formulated their expectations of birth based on what they had heard.

> I remember [my friend] telling me about, it was most comfortable for her to be squatting when she was, in her contractions and that. And that's where I get myself, I picture myself having a bath or in the shower or something at the hospital and squatting, because I think, because she described that to me [*Vicki, 22 weeks pregnant*] (page 4).

> One of my girlfriends was induced. A couple of them actually. Their water broke, you know three or four hours later, they're still there in hospital because their water broke and they got induced because things aren't happening. That's why I don't want to go to the hospital right away. But I hear if your water breaks you have to go. That's what they say. Yeah they were induced and of course their labour was more intense, more painful. One girl, one of my friends was induced and then she didn't really go into labour at all so she had to go home and then come back in another couple of days and they tried it again so it doesn't sound like much fun, being induced [*Andrea, 38 weeks pregnant*] (page 10).

> My cousin for example, his wife, they had their first about four years ago and everything was fine and you know no problems and then right at the last minute she ended up having a c-section and I'm sure there are reasons for it, I just don't happen to know what they were, and then she had another one and I guess the same thing that had to be done and it just, from my point of view everything seemed to be going along so smoothly and then all of a sudden she had to have surgery. And, I mean that's not really a horror story but to

> me it is because I don't want that to happen [*Donna, 34 weeks pregnant*] (page 4).

There is overwhelming evidence in the data to indicate that much of what the research participants knew about childbirth was learned at the time one of their peers gave birth. It seems that their peers were often more forthcoming, and more willing to offer detailed descriptions if the conversation took place immediately following the birth event. With the passing of time, however, the research participants often had as much difficulty eliciting the 'details' from their peers as they had eliciting the 'details' from their mothers. In acts of post-pregnancy purposeful acquisition, both Yvonne and Emily had limited success when they attempted to find out about their peers' birth experiences.

> A few people have told me things. Not too many people are willing to divulge stuff though. I think they figure if too many people know what it's like they might not do it, I don't know (laugh)...I wouldn't say they were very emotional, I would say they were matter of fact and they were more of "I was in labour for 12 hours," or "two days" or "I had to have a c-section" or "the baby was breech" or "I had back labour." They weren't real in depth they were just you know a little blurb of this or that, not much of an intimate conversation [*Emily, 39 weeks*] (pages 3 & 5).

> I have two sisters and they both have, one has three kids and one has two girls so it's almost like I'm going to sort of be in on the conspiracy now...[I talked to my sisters] only after I became pregnant. It wasn't something that was discussed before. I never brought it up and they never volunteered how they may be feeling. I had to be very precise about my questions like I couldn't just say, "how did it go? tell me all about it," I had to be very precise, "what happened next?" and "did they use instruments?"...They never really expressed their feelings too much, in terms of how they were feeling, in terms of like happy or sad or whatnot, just one mentioned there was a lot of pain and the other one she didn't talk about pain or anything really, I guess I didn't really want to push it because I almost felt I was snooping about these things, asking her these questions [*Yvonne, 27 weeks pregnant*] (page 2).

Prior to pregnancy, most of the research participants had learned a great deal about childbirth from their peers,

particularly when the time of transmission coincided with the birth event. At that time, conversations were intimate and the research participants got a good idea of how women experienced birth. Through discussions with, and observations of their peers, the research participants learned about the physical and emotional experience of birth, about how interventions such as caesarean section or induction might affect that experience, and they learned about the rationale behind various interventions. Learning about the experience of childbirth from their peers may have offered the research participants some insights on birth, but women's birth stories often seemed to have limited value until the research participants themselves became pregnant and reflected back on what they had heard.

Comedic and Dramatic Portrayals of Childbirth on Television

Although none of the research participants had actually seen the birth of a human baby, all of them had had vicarious access to birth through dramatic representations of birth shown on television, and those television representations helped to shape their perceptions of what birth is all about. The sounds and images emanating from the television screen provided the research participants with a framework from which they could interpret the experiences of their peers. Furthermore, there appeared to be a cross-validation between television representations and the stories the women had heard from their peers. Frequently the women would cite both sources when illustrating their descriptions of a particular aspect of birth.

When Vicki talked about her concept of prenatal education, it was apparent that image she had formulated was a composite picture derived from her observation of television and her conversations with a friend.

> I see maybe in a library or something. A room, I was just thinking of a community place that they might hold a class. Carpet and mats and person kneeling with the pregnant person leaning up against the knees and the body and the legs apart and that...I think maybe just seeing Lamaze classes on T.V. Or my friend when she had her first baby and talking about going to prenatal classes is the first time when I actually pictured what one might be like [*Vicki, 22 weeks*] (page 18).

Similarly, both Lynne and Cheryl knew from their observation of television that women who enrol in prenatal education learn how to breathe "properly." These breathing techniques were something of a joke amongst their friends, particularly amongst friends who had never before given birth but who nevertheless were aware that learning the breathing was a prerequisite to giving birth. These television depictions provided a context which enabled inexperienced peers to relate to the pregnant woman's experience.

> As far as I know, just what I've seen on T.V. and joking about that, that "hee hee, haw haw" (demonstrates breathing) you know, that kind of breathing. I was told "You will learn in Lamaze classes," or whichever they're called, prenatal classes whichever. The proper breathing that I will have to do to keep me calm, and stuff. And I guess he's going to have to know how to do it just as well to make sure that I'm doing it [*Lynne, 14 weeks*] (page 3).

> Whenever anybody, friends or somebody, first hears you're pregnant they say, "Are you learning how to do Lamaze? Are you learning to breathe?" (Inaudible) to the breathing that they've seen on T.V. [*Cheryl, 40 weeks*] (page 7).

When describing the actions of birth attendants, occasionally the research participants cited television depiction of birth as a source of their knowledge.

> Well he delivers the baby. He helps me, I don't know if, that's one of the questions I have to ask my doctor, I think it's called the episiotomy, they have to cut you, now I'm not sure if they do that all the time. So maybe he'll ask me, "This is going to hurt," or he might be telling me what I should be doing, just by going by what I've seen on films, you know there's a lot of hospital shows on T.V. [*Kim, 8 weeks*] (page 2).

> Catch the baby. So I hear. I have no idea. I really don't know. I mean, even if you've seen any of the snippets on T.V.

> about birthing they seem, it's always the last, actually it's just the actual last fifteen minutes or so [that the doctor is there]. [*Caroline, 18 weeks*] (page 4).

When describing the actions of the birthing woman herself, many of the research participants spoke about the tendency of women to scream or yell during childbirth. The research participants frequently expressed their apprehension that they themselves might engage in this behaviour, particularly, they felt that they might yell at their husbands or "abuse" their husbands. This concept was partly, but not entirely, generated from the portrayals of birth they had seen on television. Their peers had often described such behaviour to them, but interestingly, the topic of screaming during childbirth was almost always raised in connection with television portrayals. Again, the research participants appear to have formed a composite picture based on the two sources of knowledge.

> Just from what I've seen on T.V. You can see women screaming. And I have a sister-in-law I guess that, just, she was swearing and cussing up a storm but she must have scared all the nurses and doctors away (laugh). But I, I imagine, I can't, I would think that most women would make lots of loud noise [*Janice, 25 weeks*] (page 2).

> I mean I've seen a couple of movies and stuff but they, you know they certainly don't show the graphics, I mean the woman is lying on the table screaming (laugh) and you know out comes this lovely baby, this clean lovely baby but (laugh) it's not real life (laugh)...I think that people go in there with the intentions of screaming (laugh). I don't know. Like it just seems ridiculous. And then people that swear at their husbands or hit their husbands that just doesn't make any sense to me [*Anna, 20 weeks pregnant*] (page 6).

> It all depends on the woman. I think some of [what is on television] is realistic. Some women don't make, they just moan, or they groan, and they're very quiet because that's the way they are. And then other people, other women, like SCREAM, they just like scream and scream and scream, so it varies...Somehow I think of a high pitched scream somehow, I don't know. I'm not exactly sure what kind of scream, I tend to think of a high pitched scream. I know that it can be very disturbing to other women, women who have screamed because some of my friends have told me when they were giving birth,

> she was giving birth to her daughter and the nurses just had to go in and say to this other woman, she was in this other room, I don't know how many down, how many doors down, and she was screaming, you could hear her and it was very disturbing to other, you know, to my friend and other women. This one nurse just finally went in there and just basically told her to "Shut up!" you know, so. And then you have talking, talking but not really screaming but, (laugh) if your husband's there and you're in pain and you're saying things to him (laugh) [*Ellen, 20 weeks pregnant*] (page 6).

Occasionally television portrayals exposed the research participants to aspects of childbirth that they had never before considered. Based on a comic portrayal of birth she had seen on television, Vicki told me that she intended to ask her doctor about how she could distinguish between "false" labour and true labour.

> Like how I can tell for myself, like what I would experience, if I thought I was going into labour and it was just false labour, I guess because I've heard about false labour but I don't really know what it is.
> *Laurie: Where would you have heard that?*
> It was on Empty Nest. I guess she had false labour. She thought she was going into labour and went to the hospital, she wasn't in pain or anything she was just sure she was going to have a baby. But, then there's those, what do you call them? Brackman Hicks [sic] or something or other, but, the way I understand those is it's not something you'd mistake for labour, it's minor contractions [*Vicki, 22 weeks pregnant*] (page 18).

Television portrayals very often reinforced the propriety of the hospital as the birth setting. Of course, as has already been discussed, the research participants were aware at a very early age that the hospital is the "proper" place to give birth. Each time a hospital birth is portrayed on television, there is a positive reinforcement of the hospital as the appropriate birth setting and often there is a form of negative reinforcement in portrayals which showed panic stricken people who could not get to the hospital on time. Other negative reinforcement was accomplished through the implicit contrast between birth as it occurred in the "pioneer" days as opposed to in the present.

Yvonne, who planned to give birth at home, spoke about how her deep seated belief in the propriety of hospital birth had been reinforced by television portrayals of birth.

> I think I'm a typical Canadian who just think that O.K. you get pregnant you go to the hospital you have a baby. Who knows what they do in the hospital? So when [my husband] mentioned home birth I had visions of the movies, the pioneer days where the woman's in bed and the labour's (inaudible) [*Yvonne, 27 weeks*] (page 3).

Although clearly television portrayals of birth had influenced the research participants' concepts of childbirth, the women nevertheless had qualms about the authenticity of portrayals of birth on television. In judging the accuracy of television representations, the women distinguished between representations of birth in documentary television and representations in drama or sitcoms. Both types of representations were faulted on the grounds that they did not tell the full story and thereby made birth look too easy. On the other hand, television representations, particularly dramas, were also seen as making birth look as if it were more dangerous or more difficult than it actually is. Fictional accounts were often seen to hold a grain of truth, although they were criticized on the grounds that they really did not "show anything" and seemed to follow a stereotypical, sensationalized formula. These stereotypical portrayals of birth did not correspond to the research participants' perception that "everybody's different."

> They don't really take it seriously, maybe would be the thing. But, like with these, for example born in a cabin up in the middle of winter, you know you think about it. You know is this really going to happen? And even if there is somebody there, you know like there's more to, how do they cut the cord? You know, it's not just like a little rope that you can break, I mean you have to really work at it to cut it. But yet you can't leave attached either once the baby's born for as long as they do anyway...It's the practical parts that they ignore, that, unless it's supposedly born in a hospital. Like Murphy Brown was, well, I guess they do a little bit more that way to make it more real but it just seems like it's not done seriously, they don't look at all the, it looks too easy I

> guess is the thing. You know, there's a little bit of sweat and a little bit of oooing and aahing and it hurts and that's it, but it's not done realistically I don't think [*Donna, 34 weeks*] (page 10).

> Every single one I've seen in any kind of a drama is always very discrete from the side. You sort of, you don't see any of the anatomy or any of what's actually happening. You just sort of see people's reaction to what's supposedly happening...Weeping, pushing, screaming, crying, being happy. I mean it's pretty, it's a pretty standard Hollywood version of what giving birth is like...I mean I think the part that you always see in any kind of drama is always the last, the absolute last segment when the baby actually slips out but you don't see...all that comes before that. Ever. So, but I think most people could re-create that kind of sound byte or film byte, I mean you could just interchange in most movies where somebody gives birth [*Diane, 8 weeks pregnant*] (page 9).

> I would say the sitcoms, sometimes I'll notice different things that don't look right. Like I can't remember specific examples but you'll just see things on there that you'll know it just doesn't look right...but when you see the actual footage from somebody actually having a baby I would say it looks quite different. Like in sitcoms they'll always have the woman's hair all perfectly combed and makeup on and everything and sometimes on sitcoms they'll just kind of show them kind of they'll say push and then she'll go "uhnnn" or something and when you see the live footage, I mean they've got sweat pouring down them, they're screaming it out and they look like they're really in agony whereas on the sitcoms it just doesn't look the same [*Janice, 25 weeks pregnant*] (page 9).

When Janice speaks about "live footage," she is of course referring to documentary films about childbirth. Most of the research participants talked about the documentary films they had seen, and although they sometimes indicated that these films had been viewed prior to pregnancy, they more commonly referred to the documentary films viewed post-pregnancy, including the films screened during prenatal classes. The discussion of documentary films will therefore be handled in the next section.

Cultural Transmission of Childbirth Knowledge Post-Pregnancy

Prior to pregnancy, the research participants had learned all the essential elements of the cultural script; they had

learned the who, what, when, where, how and why of the conduct of childbirth. More importantly, however, they had learned a set of values, or 'self-evident truths,' which define the concept 'childbirth,' which set the agenda for what they needed to learn prior to giving birth, and which for most of them, structured where they would give birth and who their birth practitioners would be. Despite having already learned all the elements of the cultural script prior to pregnancy, the knowledge gained during pregnancy was extremely important to the research participants. During pregnancy 'childbirth' was transformed from an abstract concept to an imminent event. Whereas previous learning about childbirth had been like glimpsing a set of fuzzy, distorted photographs, now when they looked at the photograph, it was not a picture of someone else, but of themselves.

During the period of early pregnancy, most of the research participants were preoccupied with learning about pregnancy, they were not interested in learning about birth. Indeed, several of the research participants noted that they avoided thinking about birth, or that they skipped over the "delivery part" in favour of learning about pregnancy and the postpartum. In spite of their reluctance to learn about birth, there were three major sources from which the research participants purposefully acquired knowledge: mentors, books and prenatal classes. All three of these sources of knowledge are instructional transmitters: they operate under the assumption that the pregnant women had a right to, and need for, that information.

All learning episodes during pregnancy, however, did not take the form of purposeful acquisition and instructional transmission. To the contrary, the pregnant women were constantly bombarded by a set of subtle signals which redefined their relationship to other members of society. A woman's pregnancy appears to create a social situation whereby members of society respond to her in a manner which distin-

guishes her, sets her apart and invests her with a set of responsibilities inherent in her new social identity as a pregnant woman. Sometimes these transmissions were purely of the situational form, but often they moved from situational transmission to instructional transmission. Regardless of the particular form of transmission, the messages inherent in this type of transmission informs the pregnant woman that society has a stake in the birth of her child, and that there are a standard set of behaviours to which she is expected to conform.

Socially Identifying the Pregnant Woman

Of all the research participants in this study, only about half the women in middle pregnancy and all the women in later pregnancy could be visibly distinguished as pregnant women. But whether their pregnancies were visible or not, as soon as their state of pregnancy became known, the people around them responded to them in such a way as to emphasize their physical state and de-emphasize their individual qualities and character. As is illustrated by the following quotes, the research participants' individuality (who they were) became less important than their physical state (what they were):

> They all want to know if I'm feeling any different which is really interesting. They ask, "How are you feeling?" and you know implied in that is you know, 'Being pregnant how are you feeling?' Whereas before it was just "How are you?" you know like, "what's happening in your life?" so a little more focus on your physical well being and your medical status [*Catherine, 9 weeks*] (page 4).

> A little bit, yeah, "Sit down relax," or if I'm eating, you know, "Make sure she gets enough to eat. She's eating for two." You know. But, everybody will ask, "How are you feeling," you know I hear that all the time. I should wear a sign, "I'm fine." And they also want to know if you went to the doctor, "What does he say? Is everything fine?" They're just curious how everything's going so they treat me that way [*Andrea, 38 weeks pregnant*] (page 16).

For those research participants who were visibly pregnant, reminders of their physical state came both from the people they knew and from strangers.

> I remember a couple of weeks ago, [my husband] and I were shopping in the mall and I said, "I hate it that people keep staring at my stomach." He said, "Oh you're so sensitive," I said, "No, like watch people." So after about ten or fifteen minutes of doing that he said, "You're right. They always stare right at your stomach." Or they glance, then they look up, then they look away, or something, you know. And to me that's very annoying. I don't like that at all. Because they don't stare at you before but they do now. I don't mind so much when it's another pregnant lady, because...a lot of times we kind of look at each other, like you know we have this bond you know we're both having babies kind of thing. It's a little bit different than people staring [*Liona, 34 weeks*] (page 10).

> I kind of got that feeling like whenever somebody said "hi" to you or they passed you in the hall, they were looking at your stomach, they weren't looking at your face or your eyes or communicating ...I didn't appreciate "HOLY COW, ARE YOU EVER GETTING BIG," type of comments from the male gender. And even the female gender, too. And by my last couple of weeks where I'd just say "Shut up," or "Grow up," or whatever you know. Like I'd had enough. But a lot of it felt like verbal abuse...Like I really did not like what went along with it. People's comments and their attitudes. And their looks and their stares and their giggles. And I just thought that was, like I'm pregnant, I'm not overweight, I'm not eating like an elephant or whatever, I'm pregnant you know...I think that there should be more respect than there is, I don't think there is enough [*Emily, 39 weeks pregnant*] (page 19).

Many of the research participants found it disconcerting to be treated differently, particularly when such treatment infantalized them or implied weakness. Quite obviously, all the research participants in this study were fully adult women, yet the response of both acquaintances and strangers tacitly sent the message that pregnant women are not considered to be fully capable adults. As the following quotes illustrate, the research participants found that their capacities and capabilities to act as adults were frequently questioned.

> Oh, fragile! I lifted a chair the other day, "What are you doing? You should have called me!" Another woman said that. "Excuse me, this is just a chair!" You know, I thought, "What?" Another lady that was sitting beside me said, "You know, everybody thought I was so incapacitated when I was pregnant." But you're not, you know. Lifting little things, you know, and oh even where I work the men, like, "Oh, don't do that," and then the men's offices are upstairs and I, this one instance I said, "Well I'll come up," "No, no, I'll come down," so I'm thinking, "C'mon?" It was so funny. So he came down to get it. Just it's different, you know, being treated like Cinderella almost, like you could break [*Jackie, 35 weeks pregnant*] (page 6).

> Well [the people at work] all have their own opinions, you know, on what kind of shoes I should be wearing, or what, you know, they check my lunches. It's not like I, I don't mind them because at this point, maybe when I'm bigger I will mind it but, at this point I just know that they just care, and that's my, that's what I'm saying to myself, "They just care and that's why they're," you know, it's almost like they're prying, you know, seeing what I'm eating for lunch, is it a healthy lunch?...it kind of makes me kind of go, "Geez," like, "don't they know that I can do this myself?" And on the other hand it's like, well, they're just doing it because they want to make sure that I am O.K., you know [*Geri, 15 weeks pregnant*] (page 14).

As Geri's narrative suggests, pregnant women frequently find themselves the recipients of unsought advice about both pregnancy and childbirth. The research participants' pregnancies created a situation whereby other women felt compelled to relate the details of their own births or births they had heard about. Frequently these transmissions took the form of a warning about how "bad" childbirth could be. These transmissions, which the research participants labelled "horror stories," tended to evoke fear and were resented because they shifted the emphasis from the positive aspects of birth to the negative.

> I don't know what it is about women when they get together, "Oh you're pregnant, well let me tell you what happened to me." (contemptuously) It's like, "I don't want to hear this" [*Ellen, 20 weeks*] (page 2).

> It's funny because you tend to hear the gruelling, the long stories [*Cheryl, 40 weeks*] (page 4).

> Everybody feels obligated to tell you all their horror stories as soon as they find out you're pregnant [*Becky, 26 weeks*] (page 1).

The presence of a pregnant woman within a group of people frequently stimulated the discussion of pregnancy and childbirth. Such discussions took place in a variety of social settings, including business meetings, churches and informal social gatherings. Particularly as the research participants' pregnancies progressed, it became almost impossible to avoid becoming the centre of attention and the recipient of unsought advice.

> You don't like the conversation to predominantly be about your pregnancy, but people just seem to bring it up for you. So I know I was at a physiotherapy meeting where we were talking about business to do with our courses that we're doing and stuff like that, and as soon as they notice you're pregnant, like one girl who's been through two deliveries, she was sort of telling me about hers, and then another girl who used acupuncture started telling me about her delivery and so it was just all the women in the room all seem to naturally tell you, and you're looking at all these single women going, "Well maybe we should get back to the meeting, here and talk about, you know the meeting." But it just seems to be natural that people tell you in any kind of setting [*Becky, 26 weeks*] (page 3).

> Even on the Sunday mornings because I usually stand at the information desk in case anybody wants photocopying done or wants to pick up some Bible studies that they've finished or just different things so I'm just usually standing around, and the people are going by, it's a, lots of people have said, it's a very friendly homey church, and it is, everybody seems to know each other, so they walk by and say, "Oh hi," and then walk over, feel your stomach and start talking, so. And then too, I like to go to a lot of the functions that we have too, fellowships for adults or women's meetings, that kind of thing, especially at the women's meeting you get a lot of it [*Jackie, 35 weeks*] (page 8).

> And from our church, one man who is a doctor, my husband was talking to him, and after church we were going home and I was talking about something about the baby, and it's like, "Well, this is the way you do it." And I'm going, "What are you talking about? It's not even the same thing I'm talking about now." But well it's because the doctor had been talking to him and saying that well if you have to have a caesarean you want to do it so that you're not completely out because too

> many women wake up and this baby is there, like I said before, and you don't know what happened and I think in some ways you're really robbed, robbed then [*Ellen, 20 weeks*] (page 10).

> It's more people telling me things without me asking. Both friends, and acquaintances and my husband's co-workers and things. We were out for dinner last night with a large group of people and everybody start talking. There's a young, there's a baby across the table and someone else down the table who was pregnant. Of course everybody starts coming out with different little stories and people come up and start talking about that [*Cheryl, 40 weeks pregnant*] (page 3).

Although the research participants found it somewhat disconcerting to be constantly singled out and made the centre of attention, they often tolerated the well meant advice aimed in their direction. For some research participants, however, advice about how a pregnant woman should behave was deeply resented, particularly when that advice was offered by a "know it all."

> It doesn't matter really which side [of the childbirth debate] anybody is on or where they stand, again from all people I can get a very similar thing and that is, "This is the way it should be"...But there is a lot of, there's a lot of pressure about it - there's a lot of shaming involved in it. From all sorts of people. What I've heard. I've heard other people talk about their ideas about it, you know, perfect birthing, perfect childbearing, perfect everything. Some of that stuff scares as much as the stuff I'm expressing of my fear of hospitals...And then there's the shaming as well. "You feel the way you do because you were brought up on" - or your feelings are actually being pushed aside and pushed away and you're told how to feel and how to think...But there sure are a lot of zealots about the whole thing. Male and female, I find. And I think, bottom line, I don't really give a shit. It's my, I'll do what I want...I have my boundaries so I feel real resentment for having them all trampled on. Whereas it's all really up to me to, it's my responsibility so, "All right, that's enough" [*Caroline, 18 weeks pregnant*] (page 16).

> I have a couple of girl friends that have said, "Oh you should do this when you go into labour." You know, "Make sure you get an enema right away. If they don't give you one you should have one." Yeah some do offer advice about, maybe about breast feeding or things like that. But not too many. Just the odd one that thinks she knows it all. I don't take their advice, I mean I, I acknowledge it and say, "Yeah, sounds like a good idea," but I wouldn't follow it to a tee

> without you know, first looking into it...[I don't ask questions of] the ones who think they know it all. Someone who I relate to, you know is the best, we get along, we have the same thoughts and things you know [*Andrea, 38 weeks pregnant*] (page 6).

Establishing the Mentoring Relationship

As Andrea points out, there was a difference in the way the research participants evaluated the advice offered by a "know it all," and the advice offered by a trusted person. At some point during pregnancy, most of the research participants came to rely on at least one trusted person, a mentor, who would guide them through the pregnancy and into the birth. Although the research participants exhibited voracious appetites for information, at the beginning of pregnancy they were so overwhelmed by the prospect of pregnancy and birth, they did not even know which questions they needed to ask. Mentors helped the research participants to identify the important questions and they validated feelings of ignorance by encouraging them to ask questions, no matter how silly the questions may have sounded.

> I had a lot of questions but in some ways I didn't because I just didn't even know what to ask. Just there's sort of, what do I need to know? That was more the, I felt, just at first, I felt like I don't have any questions but that's just because I don't know what to ask, I don't know anything, I'm very ignorant really, almost not silly and not embarrassed, like just, I should have more to say [*Cheryl 40 weeks*] (page 23).

> It's been a close knit circle of who I ask because I guess I ask those people that I value their opinions and I know I'm going to get a, I'm going to get an honest point from them, not just general chit chat [*Kim 8 weeks*] (page 5).

The business of selecting a mentor was often conducted through a process of trial and error. If a potential mentor was not forthcoming, she was dismissed, and the research participant approached another potential mentor.

> For some reason I thought I could just drill [my friend], so to speak. I thought I could ask her a lot more questions than

> I asked my sisters. And she was quite willing to divulge the details [*Yvonne, 27 weeks pregnant*] (page 4).

> One friend just had a baby last June...She was, she wasn't, isn't the type of person that would talk openly about it. You know, she said it was tough and that's about it, and I know that she really had a really rough, rough pregnancy and a rough childbirth. But very closed on what she would want to tell me. So it's more family than anything right now that might want to talk about it [*Geri, 15, weeks*] (page 5).

In the forgoing cases, it was the potential mentors who were reticent to discuss pregnancy and childbirth, but in one case the research participant herself had difficulty discussing the topic and she consequently chose a mentor with whom no face-to-face contact was required. Then, later on in her pregnancy, she deliberately set out to cultivate a relationship with a minor acquaintance whom she felt would have the answers to her questions.

> Before I had it confirmed about my pregnancy, and there's a girlfriend in [another city] that because of the distance we're able to communicate some things a little differently than friends that you look face to face in, and when I was suspecting pregnancy, I phoned and I said, asked her about her breasts, if she had extreme tenderness and something else, and she said, "Yup, you're probably pregnant." I said, "O.K. thank you, bye" (light laugh). Other than that, I think I was just asking the same girlfriend on the phone yesterday morning, how soon, if she remembers how soon it was that her husband was able to feel the baby kicking [*Jane, 21 weeks*] (page 4).

> I'm supposed to be meeting with a dietician, we're meeting under the pretence as we're kindling a friendship, I may provoke some questions out of her. I don't know if she's going to charge me or what we're going to do, but I just want to ask her a few other questions [*Jane, 21 weeks*] (page 15).

Sometimes the mentoring relationship was initiated by the mentor herself. Through her actions, the potential mentor demonstrated to the research participant that she was willing to engage in open, frank discussion about childbirth and made it clear that she was available to answer questions.

> Everyone's been really supportive, the sister-in-laws, the baby's father's sisters and everything. They've been giving

> me advice and stuff. Which is great. And they all tell me, "If I have any questions, ask." And then at the same time I'm asking questions just to see how it was for them and what to expect. So it's a little bit of both. They're helping by offering information, and I'm asking...They've given me little things, so and so had to use forceps, had to have forceps used on them. Little things like that. Things to look for, things to do. Exercises that will help me so that when I do go into labour I don't find it so strenuous. There are lots of exercises that they wish they had done, or that they did that helped. Little things like that [*Lynne, 14 weeks pregnant*] (page 5).

> [My sister-in-law] was the first person that really opened up and told me everything. I was pretty amazed...She was just explaining that each pregnancy is different and how was I doing? and how was I feeling? And she just explained to me how her pregnancies were and I had asked her a few questions now and then. I really wasn't very, I didn't have very much knowledge at that point in time, I was only I think, gee, a few months pregnant, just in my first trimester and so I really hadn't done a lot of reading just nutrition stuff and I didn't know an awful lot so she had explained different things to me and told me different terminologies and I probably understood about half of it then and then as I learned more I understood back to the conversation what she had said and understood what she was talking about. [*Emily, 39 weeks pregnant*] (page 7).

Often one of the qualities the research participants most appreciated in their mentors was that they were available to answer questions at a moment's notice. The research participants relied on their mentors to help clarify various aspects of pregnancy and childbirth, including helping them to distinguish between normal and abnormal symptoms, helping them to choose a physician or prenatal class, and helping them to evaluate information.

> Well, like if I'm, is something normal, or is this, should this be happening? If I've noticed something or whatever it happens to be. Because you can't, I mean when you only go to your doctor once a month, sometimes you go, "Well I need my question answered now," so I'll phone my friend and say, "When you were pregnant did you have this? Is this normal?" And she goes, "Yeah" or "it might mean this," or something [*Ellen, 20 weeks pregnant*] (page 4).

> My sister-in-law has two children and I talked to her a bit about things as I've gone through the pregnancy. You know

> having certain aches or pains and I'll say, "Did you have this?" And most of the time it was "No," she didn't have this particular thing, for her it was a little different. But certain things were the same, so I've spoken to her a few times. I asked my mom as well, because she has a nursing background, just thinking that there's a chance being from the same family there'll be some similarities [*Cheryl, 40 weeks*] (page 5).

Mentors tended to acknowledge the importance of each question, and either answered the question frankly or referred the research participant to a more knowledgeable source. Information was tailored to the individual, and often the mentor would give the pregnant woman as much or as little information as she wished to hear.

> Actually I ask my sister-in-law. She has a seven year old daughter and she's a nurse as well, but she knows that I'm queasy, I guess is the word, so she leaves out a lot of the medical part but she doesn't give any information that I haven't asked for. And really I haven't asked her, I ask her things like, as I said, "Were you on time?" or just, "What kind of diapers did you use?" you know that kind of thing. Not so much as the actual, and actually I did ask her questions like about the episiotomy, I wasn't sure about that and she just explained that it's done during a contraction so you don't feel it and that's what I wanted to hear so that was fine. And you know that kind of thing. But she doesn't ever phone me up and say, "Ohhh, I was in labour for," you know, so it's good...and when we were in our classes too, you know, we'd hear a lot of information and things I didn't know or things I wasn't quite clear on and we'd talk about it and everything...You know, we'll talk about it or if I go to the doctor I mention, you know, that I've been and they ask you know, that kind of thing. [*Donna, 34 weeks pregnant*] (page 5).

Mentors took an active interest in research participants' pregnancies, often asking them questions about their doctors' appointments. Interestingly, mentors used these exchanges of information to monitor the physician's performance and to alert the research participant to actions the mentor considered to be inappropriate.

> What's quite interesting is when you get discrepancies between doctors and that. I hate to say this but my orthopaedic surgeon told me, and I was there not long ago, that because of where in my back [the pain] is I could get a cortisone shot back there, not to worry if it was getting so bad towards the

> end that I couldn't stand it. And I thought, "Great," you know, "if it gets really really bad I've got something to fall back on." And then my sister, I asked her and she said, "Make sure you ask the doctor, your obstetrician because they come out with different information." And I asked her and she said,"No, there's no way you can get anything like that, it's dangerous for the baby" (gasp chuckle)...So, my sister was the one, "Make sure you ask your obstetrician, any question you have. Don't trust anybody. She's the one who deals with it all the time" [*Janice, 25 weeks pregnant*] (page 10).

> I thought it was, that everyone had ultrasounds and then I told my sister I was going to have an ultrasound and she said, "Oh, how come?" And she said, "I didn't think they did ultrasounds on regular basis any more because they speculate there might be damage to the baby's ears or something." And no, I didn't know, you know, the doctor just, "I'll give you an ultrasound." She said, "Well I think maybe some doctors give ultrasounds all the time and others don't" [*Vicki, 22 weeks*] (page 21).

One of the most common methods mentors used to transmit childbirth knowledge was by giving the research participant one or more books. This bestowing of gifts had the effect of validating the information contained within the book, and it defined the aspects of pregnancy and childbirth that the mentor considered to be important. This action sent the message to the research participant "this is what you need to know."

> My sister-in-law moved and she went through all her stuff and found all her books her baby books and said, "Here, I'm not having any more kids." Her last set of kids were twins and she's got four, "Here you have them you read them, they'll be great." And she knows too I'm a book type of person where, for I want to learn about it and read about it, so I'm not all so totally surprised where my husband figures a book isn't going to teach him anything you know. So she knows me fairly well [*Emily, 39 weeks pregnant*] (page 7).

> Yeah, my boss gave me one [book] and then my sister-in-law, she had all her three children by the Lamaze method and one thing she said was she didn't want to lose her dignity in the delivery room. She did not want to be flailing arms and screaming. She wanted to be able to experience the whole birth, and it to be a good experience, and she didn't want to be out of control. And she wanted to be able to go through it with, so her and her husband read these books, I don't know where she got them from, and they practised it, and the

> doctor, her doctor and the nurses were really impressed with how well they coped. And I thought well, "Hey. If she could come back with that kind of a report, I'm going to try what she's done." [*Jackie, 35 weeks pregnant*] (page 11).

The research participants placed a high value on the credentials of a mentor or potential mentor. A mentor was always considered to be a credible person, who either through experience or training (preferably both), knew about childbirth. Because mentors were deemed to be knowledgeable, the research participants often expected them to help clarify "what's right and what's wrong," and to provide reassurance that the research participant was doing "what's right."

> Two weeks ago I would have called [my friend who is an obstetrician] up and told her I was freaking out because we found out we were pregnant but now I'd just tell her...I think I just wanted reassurance from her and now I'm just, I'm really excited to tell her. Just to hear all she has to say about, you know, about making decisions about what to do, whether the doctor's O.K. or not, she's going to have a lot to say about that [*Diane, 8 weeks pregnant*] (page 18).

Mentors versus Non-mentors

The women in early pregnancy tended to have a greater number of mentors than those in either middle or late pregnancy. This suggests that as their pregnancies progressed the research participants selected from among the potential mentors available at the beginning of pregnancy. The research participants chose a variety of mentors including husbands, two of whom had had children in a previous marriage (experience) and one of whom was a resident physician (training); mothers, four of whom were nurses (experience and training) and four who were not (experience); sisters and sisters-in-law, ten of whom had experience only and one who was a nurse (experience and training); friends, neighbours and co-workers, one of these had only training (an obstetrician who herself had never given birth) and the other fourteen had only experience; and two cousins, both of whom had experience but no training. With the exception of husbands, mentors were

always female, and with the exception of mothers, mentors were always selected from amongst the research participants' peers.

Other people who took an active interest in the research participants' pregnancies and upcoming births (acted as mentors), but who were not selected as mentors, included a brother (no experience), a brother-in-law (experience) who divulged more details than the research participant wanted to hear, a female friend (no experience), and a brother-in-law (no experience). In one instance, a research participant who was enroled in a university Child Development course became aware of her pregnancy after class began. Her male instructor, who had attended births as a labour support person, incorporated various aspects of childbirth and childbirth options into the course curriculum. Due to the coincidence of pregnancy and enrolment, the instructor became a quasi-mentor; the research participant valued the instructor's information very highly, but no true mentoring relationship was established as the flow of information was one way, and was non-specific to the research participant's pregnancy.

Charmaine was the only research participant unable to locate a mentor. She was the first of her group of friends to become pregnant and was therefore unable to rely on her peers for support and advice. During her pregnancy she had limited contact with her mother who resided over-seas, although even if she had resided locally, Charmaine had already discovered prior to pregnancy that her mother was reticent to discuss childbirth. Similarly, Charmaine found her aunt to be equally reluctant to discuss the matter. Eventually, Charmaine attempted to establish a mentoring relationship with her prenatal teacher, but discovered that her instructor was unwilling to play the mentor's role.

> What I'd like to get from the instructor, or what I'd hoped to get before we started but I don't think I'm going to get now, is her point of view. Like I've read all this stuff and I'm going, "Well who's right, who's wrong?" But she doesn't seem to want to give me that. I've asked her a bunch of questions

> and she doesn't really say anything. So I don't think I'll probably get that now. I think that is probably what I was hoping for before we started the class, that was somebody to tell me what's right what's wrong. I don't think that's going to happen [*Charmaine, 34 weeks pregnant*] (page 15).

Finally, several of the research participants established a quasi-mentoring relationship with their physicians. This was often, but not always, the case when the physician had been the research participant's family practitioner for many years. In all of these cases the physician was respectful of the research participant and encouraged her to discuss issues of concern. The physician/patient relationship differed from the mentoring relationship because it was based on professional credentials and communication skills not on personal intimacy and friendship.

> The first time I went in he said, "You bring me a list of the things you want to know." He said, "If I start lecturing you about this, this, this and this," he said, "You'll never remember any of it." He says, "But if you bring in a list of questions of the things you want an answer to," he says, "You bring them in, I'll answer them." He said, "I guarantee you'll remember them." And one month I went in, I had two or three things. This month when I went in I had a long list [*Lynne, 14 weeks*] (page 17).

> In my first interview with him or appointment with him, I found him very warm and open, and he made a point of sitting down and saying, "When I'm with you, when I'm having these appointments with you, this is your time. And feel free to ask me whatever you want." And I thought he spent quite a bit of time with me that morning [*Michele, 20 weeks*] (page 3).

> I had this list when I went into the doctor. But you know, he wasn't shocked at the list, he wasn't offended by it. That part made me a little happier. He wasn't insulted, you know. And he answered every question thoroughly, thoroughly, I mean, bring out the paper and bring out the pen. And he was drawing diagrams. So I felt more comfortable [*Jackie, 34 weeks*] (page 19).

Several of the research participants would have liked to establish this type of relationship with their physicians, but instead felt rushed during their appointments and felt they

did not have their questions answered respectfully and thoroughly.

> I just changed doctors to begin with and I started going to her for my prenatals. And she just, when I asked questions, the last time I asked, I had a list of questions and I asked her, wanted to ask her a single one and she seemed to run away each time she answered a question she wanted to go out the door. And I didn't think that was appropriate so I'm changing doctors again...I wanted to know about, what's it called again?, when they cut you, episiotomy, I wanted to ask her about their policies, what their policies are in hospital, if she's going to be there most of the time or how much of the time will she be there [*Käthe, 19 weeks*] (page 4).

> You don't always get your information out of your doctor. You do but you don't, it's kind of, I don't know, mind you with a lot of doctors it's like this that you kind of get rushed through. And I guess one thing that's frustrating to me is that right now with my obstetrician I'll ask a question and it's like, "Oh that's normal, that's normal." Well being my first pregnancy, "It may be normal but, and you see it all the time so it's nothing to you, but to me it might be something and if you can just say instead of 'Oh, that's nothing,' just say, 'Well no, that's O.K. There's nothing wrong or whatever'" [*Ellen, 20 weeks pregnant*] (page 4).

> There's two doctors I see, they kind of interchange each other in case one's delivering a baby...My general doctor, she referred me to these two, the one that she referred me to, I actually like the other guy better. So on the pre-registration form at the [hospital] I put the other guy's name. So I don't know who they're going to call. It doesn't really make that much difference but I would prefer the older doctor. He was nice. He just made me feel more comfortable. The other guy was younger, and I don't know, I kind of, he always has an internal the last couple of months that I went to see him and I'm not really too crazy about that [*Andrea, 38 weeks*] (page 17).

In all of the foregoing narratives, there was a discordance between what the research participants expected of their physicians and the physicians' behaviour. According to the books the research participants had read, appointments with physicians were to be regarded as question and answer sessions. The woman's role is to take the initiative by asking questions (defined in the books and/or by mentors and prenatal teachers), and the physician's role is to answer those questions. Like Käthe, several research participants

ostensibly fired physicians who did not fulfil the expected role. Andrea, however, was faced with a different problem. Her physician had answered her questions, but he had also offended her with his too frequent internal examinations. Rather than challenging him on this issue directly, she wrote the name of his partner on her hospital registration.

Interestingly, the few research participants who expressed reservations about being vaginally examined (either during pregnancy or birth) were told by their mentors that modesty was not an important issue. Indeed, the action of a stranger putting a hand in the pregnant woman's vagina must be recategorized in order for it to be deemed an acceptable practice. If this practice were performed under other, non-medical circumstances, it would be considered sexual assault. In this recategorization scheme, a near proprietary right of access to the pregnant woman's body has been allocated to birth practitioners. Practitioners require access to the woman's body in order to be able to derive technical information, and this requirement supersedes feelings of violation experienced by the woman. The books the research participants read served to reinforce the concept that the birth attendant derives necessary information from measurements of the woman's body and bodily fluids. To ensure that "nothing goes wrong," it is the woman's role to submit to these measurements. She is repaid for her co-operation by receiving the reassurance that "nothing has gone wrong," but she also expects to be repaid by having her questions answered.

Books and Other Reading Material

During pregnancy, the research participants used books and other reading material as one of their primary sources of 'credible' information. All research participants were asked where they had obtained their reading material: one half of them stated they had received material from their mentors; seven received material from their physicians (a few referred

to this material as "little books"); five received material from prenatal classes; and three received material from the Welcome Wagon. Only three research participants limited their reading exclusively to the material that they had been given. The other twenty-one women purchased reading material and/or obtained it from the library, or (in two cases) requested it from the Association for Safe Alternatives in Childbirth (ASAC).

The type of material that was purchased, that is, the material the research participants chose, did not differ from the type of material they were given. Twenty of the research participants possessed at least one manual, handbook or complete guide to pregnancy and childbirth. These advice manuals were highly valued (one research participant labelled it her "bible"); they provided answers to a full range of questions.

> The book gives a lot of information on just about every question I've had from problems in the pregnancy to preparing for the delivery to your partner's role in the delivery to looking for specific philosophies in your obstetrician and deciding whether you're going to have the child at home or in a hospital. So it's been very helpful that way [*Michele, 20 weeks*] (page 2).

As defined in the some of the books the research participants had read, the first order on the agenda was to choose a suitable birth attendant. These books outlined the criteria for judging the desirable and undesirable qualities in a practitioner and endorsed the pregnant woman's right to find a suitable practitioner.

> I read a book about questions for obstetricians in terms of our choosing a care giver, trying to find a good match, somebody that we both trust, and feel like we want to work with. Well somebody who's on the same wave length who doesn't talk about a woman, someone who's twenty-eight, as a girl, and "girls doing this," and "girls usually," you know that, we've already had that experience and it just turned me right off...Somebody that I feel, like I don't need to be friends with him, but I definitely want to feel that they're you know they're listening to me and listening to my husband and thinking the same way about intervention, and trying to see

> what their c-section rate is, in general and then specifically, you know, for first time pregnancies [*Diane, 8 weeks*] (page 7).

The books also defined which questions were important and outlined a methodology for obtaining answers to those questions. Typically, the books recommended that the pregnant woman prepare separate question sheets for the hospital, the prenatal class teacher and the birth practitioner.

> This is the [book] I've been sticking with because I figured if I float from three or four different books, each one of them is going to have their different opinion. So I want to just be able to form my opinion according to one book. From that book I'll get questions from, I'll just, you know whenever I go, when I go see my doctor for my visits, just ask her [*Kim, 8 weeks*] (page 4).

> I had my little book with a bunch of questions in it...Most of them were general questions and all the questions that I wrote down, like I had them in different ones for the doctor or for the instructor or for the hospital [*Charmaine, 34 weeks*] (page 16).

The books described the rationale behind diagnostic testing during pregnancy; that is, the books answered questions and often alleviated the need to ask extraneous questions of the physician.

> [The book] helps because I go to the doctor and I, you know, everything is routine, everything is fine. So I know that there's not really a problem. So I know when they do this test they're looking for this but it's nothing really unrealistic to be looking for at this stage. Like when they check for gestational diabetes, that kind of test. Or when they're checking your haemoglobin, that kind of stuff. You just know what they're looking for so you know that it's just routine. Or when you start to get swelling in your feet you think, well yeah they said that would be happening right about now [*Becky, 26 weeks*] (page 6).

> I ask [the doctor] a lot, in the beginning I did. But a lot of my questions are answered through the books, unless I wasn't sure about something, but just making sure that everything's normal [*Andrea, 38 weeks*] (page 17).

The books often gave clear definitions of medical terminology which helped the research participants to under-

stand the physician's language, and to use the language themselves. The emphasis placed on the learning technical language is indicative of the unequal distribution of power and status in the practitioner/patient relationship. The pregnant woman must learn the physician's language; the physician is not expected to communicate with the woman in her language.

> I found a lot of information just in the reading. Someone would mention a term or something, and I could just go to my book and find out "what does this mean?" The doctor might say something and then I'll ask him to give me an explanation...or if I'm trying to explain it to [my husband] or something, he often came to the appointments, but not always, so I'll be trying to repeat something and I can't quite remember exactly what he meant by this so I'll go look it up [*Cheryl, 40 weeks*] (page 8).

The books very often provided pictures of each stage of pregnancy and these pictures helped the research participants to interpret their experience. The scientific facts of fetal development stimulated their imaginations; they knew what their babies looked like even though no one could actually see their particular baby.

> It's almost like I see it and "Wow, that's actually going on in me?" you know, like I mean, I haven't had any morning sickness or anything, I just, I feel normal except for I'm growing and sometimes it's like, "Is there really something there?" I look and I'll go, "Look, look what this little fetus looks like now" [*Geri, 15 weeks*] (page 5).

> Very helpful is...having books with photographs of real women and how they look, feel, what they're doing at different stages of their pregnancy. That's very helpful. Also helpful is just the very dry, I don't know how to put it, just very straightforward facts, I guess. Not the personal information but just the facts of, "These are the changes you're going to see. This is what you should be doing or should not be doing." I mean that's all very, very important too [*Catherine, 9 weeks*] (page 10).

The books further provided a list of potential symptoms which enabled the research participants to distinguish between the normal and the abnormal and they offered interpretations of what the pregnant woman would, or could experience.

> It goes by trimester, by trimester, by trimester. Things to look for for both the mother and the father...For the first three months, to watch what can cause a miscarriage, what can lead up to a miscarriage, signs of a miscarriage. Then it talks about indigestion, headaches, backaches, things like that. What to look for, how to prevent it. Some symptoms, expecting morning sickness, not all women will get it but such and such percentage do and this is what happens. If you find that you're nauseous too often, you can't keep you're food down, to watch for dehydration. It get's into that. Then it talks about change of feelings. What to expect. And then it gets into what the father should expect. How his feelings will change. And it has details on, in the middle of the book, from one week to forty weeks, and what the baby inside, and yourself, will look like, and what goes on, and how things inside are changing. It gives details on, goes all the way up through the pregnancy. And then after the labour and the delivery, it doesn't really give a lot of details. It tells you what you need to bring the baby home, and what the baby will need. How you are going to go through changes for the first little while. About nursing, things to be doing. And it's actually an excellent book. It's one that I would recommend to a lot of people [*Lynne, 14 weeks*] (page 8).

The books reinforced behaviour guidelines for pregnant women by outlining the appropriate forms of nutrition and exercise, and reminding the pregnant women of the dire consequences that could result if they failed to conform to the guidelines.

> I used to be quite a rice eater but somewhere, I was reading a book called <u>What to Eat When Expecting</u>, they are not very strong on white rice, so I thought, "Well, I don't know for sure or not but we'll eat the baked potato and the skin would probably be better anyway." So I've switched whenever I can now to eating that instead...In the <u>What to Expect When Expecting</u> (sic) what is it, the ninth month or the last trimester when the brain is developing, the book was enforcing your diet as extremely important and I'm thinking, "O.K. We don't want any problems with the brain (laugh). We'll make sure to eat properly if that's what it takes, that's what we'll do then [*Jane, 21 weeks*] (pages 14 & 16).

Given the dire consequences that were said to result if a woman failed to conform to appropriate behaviour guidelines, some of the women were irritated that they had obtained this information from books rather than from official sources such as early prenatal classes and physicians.

> It seemed to me you should be learning, people should be learning a lot well before [prenatal classes begin]...So much of the damage that you can do to the baby happens in the first twelve weeks, really, all the development is then so it seems like this whole thing about folic acid, supplements and minerals, and not smoking and alcohol, I mean I don't know where people get this information if they don't check it out [*Diane, 8 weeks*] (page 15).

> [My doctor] hasn't really told me anything about how to take care of myself. A lot of things about not taking aspirin, not being in hot tubs, little things like that, I'd read about. Things that I think my doctor should have told me and warned me about beforehand because I wouldn't have known not to take a hot bath. It's just not naturally ingrained or anything. And I mean, just, I didn't happen to hear that from anybody because I really haven't spent a lot of time with people that are pregnant or have had babies recently. Just not something I heard. I didn't know it until I read it in a book. I was six months pregnant by that time. I had had a million hot baths. So God knows, something could have happened and I wouldn't have even known better and neither of my obstetricians told me any of that kind of information [*Charmaine, 34 weeks*] (page 7).

Defensive Model versus Compliance Model Material

In addition to comprehensive reading material, almost all of which conformed to the compliance model of prenatal education, the research participants were given material about baby care and labour and birth. The research participants sought out additional material regarding nutrition and exercise, local hospital facilities, and medical interventions (See Note [1]). Only six research participants obtained reading material having the "defensive model" orientation to childbirth education. When judging the credibility of the information, these research participants often tried to find a balance between the defensive model material and the compliance model material.

> I think it helps when I'm looking at those books it definitely helps to see, you know, to see some wise looking person on the book jacket with their coat on and a stethoscope holding a healthy baby but I'm also suspicious of some of that too. Like this family practitioner, who I was seeing before we decided we were going to be delivered by an obstetrician, she

had one book and then she said, "Don't, I hope you're not reading any of that," you know, "counter culture," what did she call it? some kind of, she didn't say left wing, but that was the implication that there was this underground network of information on pregnancy and birth, she said it was, you know, "I've read that stuff and it's full of lies." And I don't, I don't think that's true. I think there's a lot of things that are exaggerated in both and I don't personally know what's true and what's not true. I just kind of go with my gut feeling [*Diane, 8 weeks*] (page 17).

The first book I read is Our Bodies Ourselves which is very feminist, very feminist and I guess in a big way kind of prejudiced against the medical establishment and I guess that's where I formed my ideas. The fear of them doing something that I don't want them to do. And then I started reading other books and some of them, I mean some of them just seem so silly compared to that one because I know that that's not the way things go and you know that things don't need to be done, although some of those books are going, "Oh this is just routine and you do it," and you don't even think twice about it...I mean it really quite scared me I guess because, and its adamant pressure on the fact that, I mean they really push home births, midwives, birthing centres, which I don't know of any birthing centres in this city let alone this country. So I was kind of thinking, "God, I don't know if I even want to go to the hospital." After reading that one. And I think that's what really urged me to go to the library and pull out a lot more books to get a broader sense of, "Well, is this really the way it is?" [*Charmaine, 34 weeks*] (page 3).

Other research participants found the defensive model material confirmed their fears of the medical establishment. Alternatively, the defensive model material was itself confirmed through experience with hospitals.

I want to have good people around me who know what they're doing. But I also want, more to go towards the homeopathic way too...Because from my past experience the hospitals I don't like (laugh)...Because from what I've read, a lot of things could go wrong, from regular procedures that don't need to be done in a hospital, that kind of scares me, those things scare me [*Käthe, 19 weeks*] (page 2).

I think the [hospital] tour just confirmed everything that I had been reading. Plus I think the meeting with that one friend who had a lot of interventions, that also confirmed what I had been reading too. Because up until the time that I had been doing the reading, I didn't know that any of things were going on. So, not that it was nice to have these things

> confirmed, but you know it just sort of made it seem more real that it's not just in the books that I'm reading this but that yes it does happen and behind this curtain in this nice new room are all these instruments that they have to do everything you've read about in those books. Because you know, up until then a lot of people were saying that women in the hospital have the nursing care, the capable doctors (inaudible) I guess I really didn't want to have any of this done to me [*Yvonne, 27 weeks*] (page 6).

The research participants who had read defensive model material were more likely than the other research participants to cite it as a source of knowledge of the risks of interventions. This was not necessarily the case with the research participants who had encountered defensive model material in other contexts, such as prenatal class or the university course on Child Development. Reading a defensive model book, however, did not always change the research participant's concept of childbirth. For example, two of the research participants borrowed from the library a locally published book which compares hospital facilities, policies and intervention rates with each other and with those of the local midwives. Whereas the information contained in the book directed one of these research participants to a midwife, the second research participant was one of the only women in this study who was unaware of the local midwifery practice. Although the book helped her to choose a hospital, she missed the book's implicit message which advocated taking consumer action to avoid those hospitals with high intervention rates. For her, the presentation of intervention rates indicated only that "different doctors have different policies." She was less concerned with the comparative intervention rates than she was with the comparison of hospital facilities (such as the number of birthing rooms and the operational hours of the cafeteria).

Prenatal Education

Attendance Patterns

As the chart below illustrates, half of the research participants had attended prenatal classes at least once and half had not yet attended prenatal classes. Of the twelve who had attended prenatal classes, only seven had completed the course at the time their interviews were conducted. As would be expected, six women who had completed prenatal courses were in the later stage of pregnancy. The other two women in the late pregnancy group had each completed two prenatal classes. Of the eight women in middle pregnancy, only three had attended at least one prenatal class; one of them had completed the prenatal course, one had attended two classes and one had attended an early bird class. Only one of the women in early pregnancy had attended a prenatal class, again an early bird class. Both early bird classes dealt exclusively with pregnancy, whereas all other classes dealt with both pregnancy and birth. Although many of the research participants had enroled in programs offered by the same agency, none of the research participants had been classmates.

TABLE III Prenatal Class Attendance Patterns

PSEUDONYM	STAGE OF PREGNANCY	SELECTED PRENATAL CLASS	ATTENDED PRENATAL CLASS	HOSPITAL TOUR
Laura	5 wks	not yet	not yet	no
Diane	8 wks	City Health Unit (Central)	not yet	no
Kim	8 wks	not yet	not yet	no
Catherine	9 wks	Hospital C	1 early bird	no
Lynne	14 wks	not yet	not yet	no
Geri	15 wks	not yet	not yet	no
Caroline	18 wks	not yet	not yet	no
Käthe	19 wks	not yet	not yet	no
Anna	20 wks	City Health Unit (Central)	not yet	no
Ellen	20 wks	Independent Class	1 early bird	no
Michele	20 wks	will not	will not	no
Jane	21 wks	Rural Health Unit Hospital A	complete not yet	yes no
Vicki	22 wks	not yet	not yet	no
Janice	25 wks	City Health Unit (West)	not yet	no
Becky	26 wks	Hospital B	2 classes	no
Yvonne	27 wks	Midwife's Class	not yet	yes
Charmaine	34 wks	Community College	2 classes	no
Liona	34 wks	City Health Unit (Central)	2 classes	no
Donna	34 wks	Hospital A	complete	yes
Penny	35 wks	Hospital C	complete	yes
Jackie	35 wks	County Health Unit	complete	yes
Andrea	38 wks	City Health Unit (North)	complete	yes
Emily	38 wks	City Health Unit (West)	complete	yes
Cheryl	40 wks	Hospital C	complete	yes

Expectations versus Experience

Curriculum

Given that ten of the twenty-four research participants had attended prenatal education classes specifically designed to teach them about childbirth, one would expect that those ten women would know something more or something different about childbirth than those who had not. This was not the case, however. The quality of the research participants' descriptions of the conduct of childbirth (the who, what, where, when, why and how) differed very little, although the women who had attended prenatal classes were more likely to describe themselves as knowledgeable and often credited prenatal education classes as a major source of their knowledge.

During the interviews those research participants who had not yet attended prenatal classes were asked to describe their expectations, and those who had attended were asked to describe their experiences at prenatal class. The resulting data suggested that the curriculum offered in prenatal classes met the research participants' expectations; they expected to learn breathing and relaxation techniques, they expected to learn specifically about labour and birth, they expected to learn about hospital policies and interventions, they expected to watch films, and they expected to learn about baby care and breast feeding. The following quotes are typical descriptions of the prenatal class curriculum; the first two are from women who have never attended class and the third and fourth are from women who have attended class.

> I think we'll learn, well we'll learn about what's going to happen in the hospital, and what the room will look like, and we'll learn about breathing, like how to breathe properly so it doesn't hurt as much when you're in labour, and what's going to happen to you during labour, and you know as you dilate, what's going to happen and what's going to happen right after you give birth...We'll probably talk about breast feeding and diapering and formulas and in case of sickness [*Laura, 5 weeks*] (page 11).

> Well I would expect information about the birth process about the hospital facilities, techniques in breathing to help you through the delivery process. Preliminary information about child care. Looking after your infant once you get your infant home. Those sorts of things [*Michele, 20 weeks*] (page 10).

> You're in a big room, with all these other pregnant women, and the first half of the class is with the physio, so she talks about back care and she talks about relaxation techniques and breathing and stuff like that, and then you go into the other room and you have the nurse talking about the stages of labour and what, this is standard procedure and when to come to the hospital and what constitutes an emergency and when to come to the hospital early, what to expect when you first get to the hospital and the procedures that they'll be taking you through and then the complications as far as c-sections and stuff like that [*Becky, 26 weeks*] (page 17).

> The first hour was with the nurse and she explained more of the anatomy, she went into the labour process, that kind of thing, she did medication, she did complications all the medical part of it and then after a short break we went down and had a, I think she was an occupational therapist and we did breathing exercises, exercises for back labour, we did some scenarios. Yeah, it was really informative. I really enjoyed it. There was also a class on, we did swaddling and diapering it was practical, bathing, that kind of thing. Which was good for the fathers, I think, well and some mothers, I suppose. And, what else, and then the tour at the end. But yeah, I found them really informative and I learned a lot, a lot from them [*Donna, 34 weeks*] (page 17).

Classroom Interaction

One of the expectations held by the research participants was that they would get a chance to meet with, talk to, and perhaps form a bond with the other couples in their classes. The following quotes typify the research participants' expectations.

> I figured at that point it'd probably be fun to see, to meet, fifteen other couples that are pregnant and find out what they're doing and maybe learn some breathing exercises, that kind of thing [*Diane, 8 weeks*] (page 17).

> I'm looking forward to meeting all the other moms. Like having more contact with other ladies who are pregnant, how things are going, what their plans are and you know, just that aspect is really what I'm looking forward to. Because you

> don't get that, you don't get, well you get it to some degree from books, but not the same [*Catherine, 9 weeks*] (page 13).

> Well, I hope there will be a bond because we'll all be going through this together. I think maybe most people will be in their first pregnancy, a lot of people on their second pregnancies don't bother going because they know what's going tc happen anyway. So I think there will be this bond between us and the instructor also. Because I think people, when you see another pregnant woman it's like you instantly start talking and, but not right now because I'm not showing that much, but I think once I'm showing people will be more, isn't that funny that people do that? You know, like they can open up more to you standing in an elevator than if you're not pregnant, people ignore other people. And with kids too, they do that [*Geri, 15 weeks*] (page 15).

As was previously discussed and Geri points out, the presence of a pregnant woman stimulates conversation, she is noticed and her pregnancy is acknowledged even by total strangers. Ironically, the data suggested that the one place the research participants were least likely to engage with strangers in conversations about childbirth was in their prenatal classes. This was a disappointment to the women who had attended prenatal class, but almost all of them attributed lack of conversational flow to the particular group they were in. The following quotes are typical of the statements made by women who had attended prenatal classes.

> If she asks and nobody says anything, it's just like when you were in school, she says O.K. how does everybody feel about this and everybody sits there [silence and frowns] doesn't say anything, you know [*Charmaine, 34 weeks*] (page 15).

> Everybody seemed so shy, or wrapped in their own little thoughts... you know, we didn't hit it off with anybody. I even remember at one point, all the women were in the foyer because we were separated because she wanted to talk to the men alone...and we were in the foyer, it was so quiet, I said something just to break the ice, I don't even remember what I said, you know, to try and get some conversation going. And it helped, it did get something going. But it wasn't a flow, you know. It wasn't you know, everybody jumping in and talking. It was just, just wasn't there [*Jackie, 35 weeks*] (page 20).

> I felt they were very useful, but it was definitely not a cosy atmosphere as far as getting to know the people in your class. Actually the name of the friend that I gave you, she's having a home birth and she's talked about the, they get together in a smaller group or whatever, we haven't talked about it a lot, about her prenatal classes but the impression I get is that she knows everybody in her class...And for us it was very much, each to his own. The couples were all very, very separate. You know you'd talk as a couple, but it wasn't, it wasn't the kind of class where you get to meet other people. In some ways its unfortunate, I wouldn't have minded having something a little more intimate [*Cheryl, 40 weeks*] (page 17).

Many research participants indicated that their instructors were largely unsuccessful in their attempts to get the couples to "open up" during prenatal classes. As was the case with the research participants' descriptions of sexual education classes, the descriptions of the prenatal education classes demonstrated that they felt uncomfortable in this social situation. Feelings of discomfort, fear of mispronouncing a word and fear of asking a "stupid" question all inhibited many of them from conversing in an open forum.

> You're not even sure how to pronounce some of the words. I can see that, you feel uncomfortable. But I mean you're breathing in front of these people with your eyes closed "hooh, hooh," you know, that's uncomfortable too, in front of all these strangers but I think it just depends. My boyfriend wasn't shy. I remember, "Does anybody know what the cervix is?" My boyfriend's hand shoots up. You know everybody else is "oh" you know and he's, it just depends on the personality too everybody's different. But it was pretty quiet, you don't get a lot of questions. I mean she said, "No question's stupid. Ask whatever you want" [*Andrea, 38 weeks*] (page 22).

> I notice after class that women go up and talk to the instructor, the guys don't, you know. And if, the guys are often the ones who are making like, light jokes of things in class more so than the women. If anybody says anything then it's something that will lighten the mood and it's usually a guy...Maybe it's because most prenatal classes are attended by people who are having their first child, right? So maybe they're really nervous about the whole experience [*Liona, 34 weeks*] (page 19).

Prior Knowledge of Material

The inhibitions and discomfort the research participants felt are of particular interest considering that many of them described the material covered in prenatal classes as being merely a repetition of what they had already learned through their reading. In other words, they already knew the material, but felt constrained to exhibit their knowledge or to claim personal authority over their knowledge. Before beginning of their prenatal education programs the research participants prepared themselves (or intended to prepare themselves) so that they would know which questions to ask.

> I've been putting those last few chapters off to the end but I'll probably read up on that before I go in and make sure I've got all the questions that I have that I can ask them, ready. Yeah, well it's kind of nice to have a good overview of it and then if they, if they basically, if what they tell you is quite similar to what you've read it's kind of nice if they jive, nice to be informed before you go, and that's the way, when I went to university I always tried to read the text-books before class so that when you went it's very easy during that part of it. And then otherwise if you just go in there uninformed, by the time you think of the questions you want to ask, the course could be over. This way you're ready to ask all the questions you want [*Janice, 25 weeks*] (page 19).

> We've been to two of the prenatal classes thus far, and I haven't really learned anything there that I didn't already know from the books I've read. I'm kind of hoping that the next class we start labour preparation, and maybe that will give me more of an indication. Because I think with labour, that's something you really can't read about, you really have to listen to other people tell you about they're experiences to maybe judge. I think it's probably really different for everybody, and you really can't imagine or prepare yourself for what it's going to be like because you have really no idea. I can't say as she really taught me anything else. Like I said everything she's being saying in class thus far, there's been two classes, I've read in books [*Charmaine, 34 weeks*] (page 7).

> It really seemed like all of the information wasn't necessarily new but it clarified questions that we had and other information that we'd heard and the stories [*Cheryl, 40 weeks*] (page 20).

Social Exclusion of Single Women

Unlike sexual education class where the genders had been segregated, in prenatal education classes there was a social requirement to bring one's spouse or partner. Michele, a single woman, believed she would be out of place in a class designed for couples and consequently decided not to enrol in prenatal classes. Penny, too, had this feeling, when she brought a friend rather than her husband to her first prenatal class.

> I'm having the child on my own, and the natural father lives in [another city] so he can't participate. If he were in Edmonton, I would probably go and we would do it together...But I see them as being designed for couples and so I don't feel comfortable on my own going into that situation [*Michele, 20 weeks*] (page 10).

> I felt very out of place for the first two classes because my husband was working out of town and I had to take a friend with me. And I felt like all the other people were couples there and I was there with a woman and I think they thought I was some awful single mother or something. Pretty uptight group. Just the way it worked out, I guess, the luck of the draw. My friend felt very strange too, being the only non-pregnant woman there, besides the instructor. She just felt really strange. People were looking at her funny [*Penny, 35 weeks*] (page 12).

Major Benefit to Husbands and Partners

Many research participants stated that, unlike themselves, their husbands had not actively learned about birth by reading the books. They indicated that their primary motivation for enroling in prenatal classes, therefore, was so that their husbands could learn the material.

> I think with my husband too, it'll open up his eyes because you know, kind of, he doesn't read the books and I'll show him, "Look at this part, look at that." But he doesn't sit down and read the books so I think the prenatal classes will open his eyes and what's actually going to happen and go on [*Geri, 15 weeks*] (page 15).

> Mostly I signed up I think for him, not for my benefit and really to learn the breathing, but the other information, I signed up for him to learn because he's not one to sit down and read the book, I think he would get more out of listening

> to somebody talk and tell him. And more from it than if I do it. He listens to me and he's quite willing to let me talk about it, but I think it's different coming from somebody else than from the wife. So we're looking into the possibilities of going through the prenatal course again here in the city maybe [*Jane, 21 weeks*] (page 19).

> A lot of it was so that my husband could learn a lot of the things. I had read a lot of the stuff already. But he didn't have time to do something like that. So I thought it was quite important for him to find out what was going to go on. How to be a good coach [*Penny, 35 weeks*] (page 11).

Defensive Model Classes versus Compliance Model Classes

Only one research participant attended a prenatal class that clearly conformed to the defensive model. The information presented in her classes alarmed her and prompted her to explore her options more thoroughly than was the case with most of the other research participants.

> The negative to the class was how I was afraid, it gave me, made me apprehensive. About the doctors breaking your water, the doctors doing this, against your will. And when I approached the doctor with the questions that arose because of these fears I, in my opinion, they were unwarranted. Because he says, "No, we don't do anything unless it's absolutely necessary. And if you say no to drugs, it's no. We don't give you any drugs just to give you drugs." And then she said, "Just make sure that you're the, you're the consumer, if you have a concern, voice it." You know, she said, "You're the consumer, make your requests known" [*Jackie, 34 weeks*] (page 19).

Jackie did not speak of the potential consequences of such procedures as "breaking your water," and indeed it is possible that the prenatal teacher may have not given her this information. Instead, the information Jackie retained is that such procedures would be done against her will. On this issue, the information Jackie learned from her defensive model prenatal teacher contrasts with that Donna learned from her compliance model prenatal teacher. In Donna's case there was no implication that a woman should object to having her water broken:

> You can read a book about labour but when you actually see it on a film or it's told to you by a nurse it just, it helps you understand. And they would pass out different things like for how the water is broken. That was one thing I didn't know, I didn't know the doctor would do that, or could do it. And they pass, like they have a little crochet hook that they use and they would pass these things around...Just so that you're familiar with them when you see them. And you know that was good [*Donna, 34 weeks*] page 17).

In contrast to Donna who felt that the information presented at prenatal classes helped her "to understand," Jackie was unnerved enough by the prenatal class material to explore the option of giving birth at home. Neither her husband, her family, nor her friends supported this option. Most astonishingly, the prenatal teacher who had vehemently advocated the consumer's right to choose, was also unwilling to support her.

> The lady that was teaching our prenatal class, she didn't say anything about risky, but she said, which really swayed my husband, "For your first child, I would suggest going to the hospital just because you don't know how your body's going to react to a pregnancy." You don't know how your body's going to react in the hospital either. I mean what's the difference?...My husband said to her, "My wife wants to have a midwife. What do you think of that?" She goes, "Well, I wouldn't suggest it for the first one because," and I thought, "C'mon!" you know. I mean, I'm older, you know it's not like I'm jumping in to something, you know without even researching it, you know. And I don't think it's, I really don't think it's as risky as, because it's unknown. Everybody has a fear of the unknown, because it's still just being brought into the light and recognized. It's just starting to be [*Jackie, 35 weeks*] (page 13).

Hospital Tour

Eventually, after discussing the issue with her physician and taking a hospital tour, Jackie was convinced that she need not worry about interventions being done against her will.

> I was surprised. We went to the hospital. My husband was really nervous, because he had some misconception about it being an operating room, and when he went in there he thought, "Wow, this is nice." It was like a bedroom, you know you have your closet, you have your shower, you have everything at your finger tips, your T.V., he was just so impressed, and he

> thought the bed was pretty cool too, the head came up and where you put your feet and where the baby drops out, you know. And it was a, I was very impressed. It was soothing, it really made me relax...I was still trying to convince [my husband] to do the midwifery thing, and I told him that's what I wanted, but he just wouldn't, he can't relax with that, so when he saw the operating room, the operating room? the birthing room he said, "Yeah, I really feel better with this." Even though I'm the one who's giving the birth, you know, I need him to be able to be there for me so he feels in this type of atmosphere he'll be in control as the coach (laugh) [*Jackie, 35 weeks*] (page 2).

Like Jackie, all but one of the seven research participants who had toured their respective hospitals felt comforted by what they saw. The research participants described the rooms as having a "homey" atmosphere as well as having a full complement of medical equipment and personal amenities. For Yvonne however, the hospital tour had the opposite effect. Her tour of the hospital supported anti-intervention arguments contained in the defensive model material she had read. The tour became the determining factor in her decision to have a home birth.

> I didn't like some of the approach though, they told you that when you got into the room this would be done, you'd have to have this monitor strapped on you, and might even have an internal monitor. And she described what it would do and how it works, and nobody asked any questions. They all just stood around and listened to this nurse give her spiel and it sounds like "O.K. this is how it is," she's telling how it is when we go in, "this is what we can expect. Here's the laughing gas, you can have some if you want. We have sleeping pills, we advise you to take some sleeping pills as soon as you get in, that will help you relax, and who knows maybe when you wake up you'll be fully dilated. And do you want pain killers? We have pain killers. Just ask us"...Plus the bed was so narrow, it was only about two feet wide. I know how I am right now, constantly turning and moving around and trying to get comfortable. So even though I think they're trying to make progress and you know in terms of the interventions, "We don't do episiotomies unless it's necessary." Who decides when it's necessary?...I don't want to be in the position, because I thought that I get vulnerable in the presence of quote the authority, the doctor and whatnot and probably, especially you know during labour and you're tired and everything, "Well we're going to have to do this, we're going to do this, we're going to give you some of this," it would probably happen to

> me before I even had a chance to think about what's being said. So I don't know about having all these things done. I would just rather stay home and just work it out [*Yvonne, 27 weeks*] (page 6).

Documentary Films

Except in a few cases, the research participants discussed only the documentary films they had viewed in the post-pregnancy period, and occasionally these documentaries focused more on reproduction than on childbirth. Those research participants who had attended prenatal classes tended to discuss the films they had viewed in class. Seven of the research participants described television documentaries concerning water birth, one of which had aired just a month prior to the commencement of the data collection phase of this study. Unlike any other television program or film, the documentaries on water birth generated a lively discussion of the issue among the research participants and their peers.

> My husband actually brought it up to me one day. He said, "Do you think that they have got that here?" And I said, "I don't think they have it in Canada." And I said, "I don't know," I said, "I know it's popular in Europe and over there, and I don't know." But what you do, is, at the time when you're ready to give birth, this is my opinion of it, you sit in a hot tub, type thing, and your baby is born into the water, and with you sitting up and the baby already being in the water it's just an easier transition for the baby. And it actually seems like a pretty neat idea and I don't know why they don't have more of them here [*Geri, 15 weeks*] (page 13).

> I have a girl friend that's pregnant, that's actually one week ahead of me. And she saw it too. And we sort of discussed the uniqueness of it, and how that might be kind of neat. And she actually said that she was going to march to her doctor's office and find out if she could have a water birth (chuckle) [*Anna, 20 weeks*] (page 7).

> I talked to my sister. It was just after she had her baby, right, and she said that she spent a lot of her time in the shower at the hospital. And she said, "If I had known," you know, because on the T.V. show on the 2020 thing the woman had hardly any pain, **yeah right** [sarcastically], and everything just went so well...And so my sister said, "If I'd have known that I would have taken a face cloth and put it over top of

> the drain so that the shower could have filled right up. I could have had the baby just like that." But then, since then I have heard about like a baby drowning...I heard it on the radio or read it in the newspaper or something that was being born that way. So I think that sometimes they decide that they're making these really big medical breakthroughs and then they don't really realize what they're doing until something bad happens. So I don't know, I'm tentative about it [*Liona, 34 weeks*] (page 21).

> My brother-in-law told me about it. It would have been interesting to see, because I guess that's where they actually give birth under water. And the child comes out and they take it out of the water, the idea of it being its coming out into the environment it knows, and apparently its supposed to be more relaxing...It sounds interesting, the idea of having a nice hot bath seems really comfortable, I can see how it would be really relaxing, at least for me anyway. I'm a bath person. But, I wouldn't mind seeing the documentary actually, I don't know how to find it [*Cheryl, 40 weeks*] (page 16).

As the research participants' interpreted it, the message of these documentaries was that water birth was better, more "relaxed" and more "natural." Water birth was also described as being an unorthodox practice, available not locally (unless at home) but elsewhere, outside Canada. Another form of unorthodox practice was described by a research participant who had viewed a documentary film on therapeutic touch. The material presented in the documentary influenced the research participant in her decision to hire a woman who does therapeutic touch to attend her birth. Again, the material presented in this documentary emphasized that therapeutic touch was "better" than conventional childbirth practice.

> We saw a little T.V. show on therapeutic touch and I thought that was helpful. Because I've been studying on my own, sort of homeopathic ways of doing things to begin with, and that I thought was very helpful...It was on birth and, they showed three different birth processes. One was therapeutic touch, one was a delivery without any intervention, and one was in the hospital with all the interventions, you know pain killers and everything. And they showed the comparison. It was really interesting to see it. The one in the hospital, they did all the intervention where, like one usually sees in the movies or whatever. The one where they didn't do any intervention, there was a midwife with her, and she was in a, more like in a bedroom setting, it didn't go into much detail. I

> didn't pay attention to that one really (laughter). Anyways, the ones with the therapeutic touch, there were two, two actually women doing the therapeutic touch, and she didn't have, the screaming wasn't loud at all. Like she just moaned basically, when she went through the delivery. And she had an extremely long delivery to begin with. And I thought that was quite fascinating [*Käthe, 19 weeks*] (page 13-14).

In contrast to the messages about better birthing methods imbedded in the television documentaries, the films presented in prenatal classes presented the message that "everybody's different." Some women in the films managed to give birth without availing themselves of various medical techniques and some women found that they required the conventional techniques. In essence, these films contained the message that an individual woman's response to birth and her abilities to cope with labour cannot be known prior to the event. The films therefore served to warn to pregnant women against formulating idealistic expectations about birth.

> That was pretty emotional actually. I kind of liked watching that. They showed four different births. One was very straightforward, uncomplicated birth. They showed one woman having a caesarean with just an epidural which I thought was quite neat. That was very emotional. They showed one woman being induced. And the other one was a second labour that went very quickly [*Penny, 34 weeks*] (page 8).

> All of them did show a birth or one or two births. A lot of them had discussion on it as to what was happening...And then going through the birth. It seems to me we saw one that did have a little bit of a complication that had to be taken in. I think we witnessed some on video that did show a caesarean and what was done through there [*Jane, 21 weeks*] (page 12).

The research participants had different reactions to the films they had seen. As the following quotes illustrate, the films provided Andrea with a dose of reality. The films constructed labour as a problem which she needed to overcome, then the breathing and relaxation exercises presented by the prenatal teacher effectively solved the problem posed by the film. Emily, on the other hand, considered the films to be unrealistic. According to the knowledge she had obtained from

peers, the experience of giving birth was much worse, and much more extensive than she felt was idealistically portrayed in the prenatal films.

> Before I went to classes I, "Oh labour's going to be a breeze," and then I saw these movies and I was scared after that... There's these women, "Ah, ah," and they're in pain and they've got back labour, trying to get comfortable, trying to deliver this baby and pushing and you know they're, "I can't do it," and just they were having their troubles for sure, but they, you know the breathing, I'm sure, I haven't practised my breathing but I remember how to do it so hopefully when the time comes I can remember how to breathe properly and it'll help me, I'm sure it'll help me because they actually did a demonstration where you held a piece of ice in your hand and you're using the breathing and the pain went away, and another time you held the ice and just breathed normally and the difference was incredible. [*Andrea, 38 weeks*] (page 15).

> I think it was really unrealistic. They had three women, three examples of women, and of course it was camera controlled...You just see what they wanted you to see...I think it's like a propaganda thing to me. They're showing you what they want to show you, the positive aspects. You're not seeing the negative aspects. You're not seeing when they went totally nuts or when the husband fainted or, you know they're not showing you a negative picture...I mean I've heard some of my friends, or people I work with say that they swore like crazy at their husband or, you know they did this or that. I don't know, just the films didn't see realistic to me. They seemed too good to be true [*Emily, 38 weeks*] (page 12).

A few research participants remarked on the aspect of voyeurism inherent in the photography of birthing women. Although the photographs were considered to be helpful, these research participants did not want similar photographs to be taken of them.

> I know they say after you've had a baby you don't have any more dignity, it's like everybody's seen you so it doesn't matter. But they say you don't really care about who sees you after a while...I know this, like all these women getting filmed for the film I thought "I would never let myself be filmed"..."No cameras, sorry, you don't come into my delivery room with a camera" [*Becky, 26 weeks*] (page 23).

A few research participants had also received suggestions that someone videotape their births for them. These suggestions met with a mixed reaction; Laura was seriously contem

plating having her birth videotaped on the condition that the traditional camera angle was not used, whereas Donna was absolutely opposed to having a camera in the birthing chamber.

> I might have it video taped, (giggle) I was thinking of it. Make sure you get a good angle (gestures down abdomen with hand) (laughter). Well as long as like over top of my stomach this way (i.e. her own point of view) rather than this way (i.e. a shot of her genital area) (laughter). I think that would be neat [*Laura, 5 weeks*] (page 8).

> [My brother] wanted to video tape the birth and I told him, "Forget it. No way" (laugh). He likes that, but his is more from a medical point of view, he likes anatomy and that kind of thing so that's what he was interested in...I guess maybe because it's my brother, from that point of view you don't really want him looking, but even if it was my husband or the doctor that said, "Well this is a routine thing, we videotape it." Ahhhhh, oh I just, I don't know. I think because I wouldn't want to see it...I just thought, "That's not something you really need to film." And I hear of families that film it and show their kids later and I just, "No," I'm too conservative for that kind of thing [*Donna, 34 weeks*] (page 7).

In contrast to the research participant's descriptions of the voyeuristic aspects of documentary footage of birth, they did not detect a similar voyeurism in documentary footage which portrayed the zygote or embryo in television programs about human reproduction.

> I saw, what was it, on ACCESS TV about a week ago, and it showed the sperm entering and it showed the sperm going to the ovum or whatever it's called, and how the baby develops and it was all cameraed inside, it showed the developing fetus and everything and it was really quite interesting and it also showed the birth. And I was just glued to it, it was just so interesting to see what, especially what was happening inside, you know how it was developing and stuff [*Geri, 15 weeks*] (page 5).

> They have a nature show, I don't know what kind of show but some one of those shows on, where they had, where you could see the baby in the womb move around like you had a little micro like a little I don't know what you call that inside and you could see it move around with the flesh and everything. That's what I've seen. And it looks really interesting (chuckle) [*Käthe, 19 weeks*] (page 7).

In their enthusiasm for the wonders of photographic technology and scientific fact, the research participants completely overlooked the fact that in order to take these photographs, some intrusive measure had to be performed on a woman. In these programs, the disembodied fertilized egg became the focus of attention, and the woman in whose body that egg was nurtured, completely disappeared. It is as if the fertilized egg has an existence separate from its mother. None of the research participants raised questions about how these photographs may have affected the woman, even though many of them remarked on the intrusiveness of pictures taken of birthing women.

Evaluating Information: Sorting Fact from Fiction

In the following section, the research participants' knowledge and evaluations of various alternatives and interventions in childbirth will be presented. This will include their evaluations of the birth setting, birth attendants, physical sensations of labour, natural birth, and four common interventions (episiotomy, induction, caesarean section and pain medication). This section is slightly different from the forgoing sections in that the focus of the presentation is not on the circumstances under which the research participants learned about these aspects of childbirth, but rather on a comparative analysis of how the research participants evaluated the information they possessed. In making judgements about the credibility of information, the research participants relied on their "gut feeling" (i.e. whether the information was consistent with their concepts) and on the credentials of the source of the information.

The Hospital Birth Setting

All but one research participant planned to give birth in the hospital setting. When they described the hospital setting they emphasized desirable qualities such as "homey,"

"comfortable," "flexible," "equipped," and "sanitary" but also mentioned undesirable qualities such as "smelling like a hospital," "noisy," and "impersonal." Their evaluations of the hospital setting were often made in relation to their evaluations of the home setting. Those features which distinguished the hospital from home (equipped/sanitary) were listed as advantages of hospital and as disadvantages of home. Correspondingly, the contemporary hospital setting was frequently described as being "not like a hospital" (i.e. not stark, not white, not bare, but comfortable, warm and home-like). In other words, the research participants considered that the attributes of the home setting were advantageous, and the extent to which the hospital setting could imitate the attributes of the home setting resulted in a transfer of the advantages of home to the hospital. The institutional aspects of the hospital (odours, sounds, strangers) were viewed as being disadvantages of the hospital, and lack thereof were seen to be advantages of home.

As Charmaine assessed it, giving birth in hospital would entail a power struggle between her and the hospital staff. She felt that the hospital staff would attempt to control her and make her do things she did not wish to do. As a consequence Charmaine intended to submit to hospital policy only when she felt it was in her own interests to do so. Although she was clearly uncomfortable with the idea of giving birth in hospital, she had never investigated the possibility of giving birth at home. Ironically, her description of an ideal birth included the suggestion that it would be better to have a precipitous birth at home than to either give birth in the hospital or have a planned home birth.

> I hope to wait at home for as long as possible so I can do what I want and eat what I want and drink what I want, and move where I want and have a shower and everything. I imagine once I get into the hospital it's going to be pretty much them trying to tell me what to do and where to go and how to do it. I'll be fighting them the whole time going, "No I don't want to"...So I think ideally I would like to have it at home. I'm

> kind of hoping for a really quick labour thing to happen you know, "Oh, can't go to the hospital. Well no, the baby's crowning." And making [my husband] do it. I know that's not going to happen. Labour takes a lot of time and I probably won't get away with that one [*Charmaine, 34 weeks*] (pages 2 & 16).

In contrast to Charmaine (who clearly subscribed to the defensive model), Becky felt that giving birth in the hospital requires the woman to accept hospital policy. Implicit in her statement is the suggestion that a woman who is not willing to abide by hospital policy would be better off giving birth at home. Becky recognized that giving birth in the hospital entails constraints on the birthing woman, but she nevertheless accepted these constraints.

> I think in a home birth it's very much what you want, it's very much shaped the way you want things to go, you're in your own environment. There's obviously less medical intervention, you're more in control, you can say what you want to be done and what not to be done. Whereas at a hospital you're bound by their policies, their procedures. You know, "You will have this, you will have an I.V., you will have a fetal monitor, this is the way we do things." So I think if you agree to go to a hospital you have to agree to go by their policies [*Becky, 26 weeks*] (page 13).

Cheryl's evaluation of the hospital setting was somewhat different than Becky's. She did not believe that the practices surrounding birth in hospital are as corrupt as "public opinion" would suggest. The callousness with which hospital birth is regarded, appeared to Cheryl to be unsubstantiated. In her estimation, this callousness may have been a feature of hospital birth in the past but it no longer applied in modern hospitals. Cheryl did not feel constrained by hospital policies, but rather admired hospitals for making choices available to women.

> I think public opinion of hospitals is not always, that they're going to, it's all for the convenience of the doctor. And I've heard quite a few people tell me that, "Oh well they pretty well line you up for c-sections so the doctor can plan to have his weekend," or something like that. And I'm sure that's happened (inaudible) but I guess maybe I'm a little more optimistic. I don't think the majority of doctors are

> doing that any more. I don't think they do it like they used to do. At least some used to, its more, I guess less of the artificial. That's my perception of it anyway...I think it was true at one time but I think its usually, I mean maybe its still true of certain hospitals and maybe of certain doctors, I think it really depends on the individual but the impression I'm getting, at least from what I'm seeing in terms of hospital and that kind of thing is that its much more of a human process than before. Now you can have the baby, they're not going to take it away from you and keep it. You have the choice there's more choices than in the past [*Cheryl, 40 weeks*] (page 9).

Like Cheryl, Laura viewed hospital birth as the best option. In Laura's judgment, the pregnant woman is required to accept responsibility for the outcome of the birth. She exercises that responsibility by choosing the (culturally) appropriate birth practitioner and birth setting. She believed that it is safer to give birth in hospital than at home, and even though her friend intends to "educate" her about home birth, Laura was firm in her conviction that "you can't change someone's beliefs."

> I guess it's because you're supposed to have babies in hospitals. But I'm not one always to do what you're supposed to do. But in that situation, I'm not a doctor. I believe that if I was to make a choice and have my baby at home and something happened, I mean that was my choice, I couldn't even live with myself if something happened. So, I just think it would be better all around to have my baby in a hospital and I have an excellent doctor so I'm confident in him...When I first heard about my friend having a home birth I was curious I wanted to know about this, and I thought, "Oh well, O.K. that's different." But after I thought about it, and there was just no way I would do it. And she wants to educate me on it and I told her that she would have to educate me first before I could argue with her about it. But I mean, you can't change a person's beliefs but I think she's going to try. She's not going to get very far (laughter) [*Laura, 5 weeks*] (page 7).

Home Birth and Midwives

As Laura's narrative indicates, it was not at all unusual for the research participants to be aware of the options of midwifery and/or home birth, and most of them learned about

these alternatives through listening to women's birth stories. Although only one research participant had made definite plans to give birth at home, a further three gave home birth serious consideration. Like many of the women in this study, Anna described her ideal birth to be a home birth, but unlike most of the other research participants, she did not reject the idea because of the safety factor. Rather, Anna did not plan to have a home birth because she had learned through experience that her family disapproved of it.

> I think that if we had more midwives, and midwifery was more of an accepted practice, and it didn't freak family members out, then I probably would choose to have a home birth. But because I know it would cause a lot of stress with many family members that it probably is just better for me (chuckle) to go to the hospital [*Anna, 20 weeks pregnant*] (page 11).

Whereas Anna's freedom to choose a home birth was constrained by her sense that her family would disapprove, Käthe's mother encouraged her to give birth at home with a midwife.

> Why I was thinking of getting a midwife? Actually my mom mentioned it to me. And I, I wouldn't mind having a midwife. I wouldn't mind having a home birth, the only thing that's stopping us is really the money right now. And maybe because there's twins. I don't know, there might be, the possibility is there. And if I do have twins I'd rather have them in the hospital because it's just a little safer there [*Käthe, 19 weeks*] (page 4).

Like Anna and Käthe, many of the research participants rejected the idea of giving birth at home. As the following narratives illustrate, many research participants supported the option of home birth in principle, but rejected home birth for themselves because they worried about possible complications which they felt could not be effectively treated in the home setting.

> I guess for some people, if they feel comfortable, you know, they want to have the baby in their own home, house, having a midwife to help deliver the baby, and you know, they've had babies before or there's no problem, no anticipation of any problems or something, and they feel comfortable with that then I don't see why someone else should be able to tell them

> they can't do that. I think it'd be neat to have a baby in your own home too...[My professor] talked about how it was, you know, if there was no reason to be concerned about any difficulties or problems that might happen during birth. He said he's in favour of it and he knows a few midwives. He recommended though that for your first child to have it in hospital, just because you might not know what to expect [*Vicki, 22 weeks*] (page 13).

> I know a girl who delivered [four months ago] I think, actually I haven't seen her since then but she had a midwife and that's fine for her. I can't say if it's good or bad but she seemed to want to go that route. Other people are totally against it, "It's not right. It should be done in a hospital. Midwives aren't doctors. What if something goes wrong?" I'm sort of of the view I guess, it's fine, it's not the way I would want to go but I'd worry about what if something happened at that last minute? You have to take this girl to the hospital, whoever gets, she goes to the hospital they have absolutely no information on her at all, they know nothing about her pregnancy, nothing, she just comes in and what can they do? And I think from that point of view I would, but again it's for every person to decide [*Donna, 34 weeks pregnant*] (page 11).

Whereas Vicki and Donna described the dangers of home birth in hypothetical terms, Diane's best friend actually encountered difficulties in giving birth at home. Diane knew that the complication that arose was "rare" and she knew that her other friends had been successful giving birth at home. Nevertheless she was convinced that this rare, devastating complication could probably have been prevented if her best friend had given birth in hospital.

> My best friend had a really terrible experience with her first child, and so it was, she was really the first of my friends to have a baby. She had it at home, with a midwife and just, the baby's, he's really, he's a vegetable basically, and he's very very sick and always will be...Although I know that what happened to them, it was really rare, a really rare thing, I know that complications do happen all the time...So we're definitely not interested in having a home birth...I've got a lot of friends who've delivered at home. I've got another friend who had a baby in April, her second and she had both her kids at home...and she was up doing dishes as soon as the baby was born. I mean she's just like, "Nothing to it, no problem, no pain, no big deal." [*Diane, 8 weeks pregnant*] (pages 1&5).

Few research participants knew people who had suffered such severe complications, or who had experienced the death of the baby. The four baby deaths that were mentioned, two of which were premature babies, all occurred in the hospital setting. None of these research participants, however spoke of the deaths as being preventable; the deaths "just happened." As Emily's narrative illustrates, the inability of the medical staff to account for the death of a baby was interpreted to mean "there was no reason." Or to state it another way, if the most authoritative people cannot give a reason, then no reason exists.

> Babies die, some babies die for lots of reasons people don't know. Some, no reasons at all. And I work with a person who's had an experience like that too. They had absolutely, they could give her no reason at all, why the baby died [*Emily, 39 weeks*] (page 16).

This set of quotes reveals the deeply imbedded cultural concept of the attributes of the birth setting. Whereas Diane's best friend's experience greatly detracted from the appeal of the home setting, Emily's co-worker's experience did not detract from the appeal of the hospital setting. Both research participants had similar information with which to evaluate the safety of a particular setting, but both these stories reinforce the cultural construction of "hospital" as being safer than home.

The Roles of Hospital Birth Attendants

The research participants envisioned that throughout the process of labour they would be left alone with their husbands/partners in a hospital birthing room. Nurses were not expected to stay with the labouring woman unless something had "gone wrong," rather, the women expected to be "checked" by nurses who "pop in" intermittently, they expected to be apprised of their "progress," and they expected the nurses to use their expert judgement to make decisions about whether both the labouring woman and her husband/partner were perform-

ing adequately. To state it another way, the act of labouring was envisioned as a solitary performance conducted by the labouring woman and her husband/partner under the supervision of the hospital staff. (This description of the role of birth attendants is almost indistinguishable from that described by Beaton & Gupton, 1990 in their Winnipeg based study of women's expectations of childbirth).

Some of the research participants regarded the solitariness of labour with some dismay; logically it did not make sense within their concept that "something could go wrong" at any moment. If something were to "go wrong" during labour (the portion of the event over which the woman and her partner have dominion), they would have the defacto responsibility first to diagnose that a problem existed, and second to summon the nurses. Having the nurses "within calling distance" [*Cheryl, 40 weeks*] (page 3) contributed to the idea that being in hospital during labour increases safety, however it did not mitigate the idea that the parents would be "in charge" [*Jackie, 35 weeks*] (page 21) of the labour.

Whereas the labour process was envisioned as a solitary performance, the birth was envisioned as being inclusive of at least two nurses and "hopefully" the woman's own physician. At this point the medical and nursing attendants were envisioned as moving from a supervisory role to a governing role. During labour the research participants envisioned themselves as having freedom of movement; moving from the chair, to the bed, to the shower, to the hallways and back again. In contrast, during the birth the women envisioned themselves as having restricted movement; at this point they would be told how to position their bodies and they would be told when they could push, and how they should push. As Emily stated:

> I figure I can pretty much do whatever I want until we get into the last stage. Because I asked my doctor about it, I said, "Can I squat or do this, or do that?" and he said well, he pretty much prefers the old fashioned method with you sitting down laying down sort of thing feet in the stirrups

> sort of thing and them ready to catch the baby coming out. He prefers to deliver that way and I would prefer to if I want to stand up, stand up, or if I want to stand on my head, or whatever, because I want to be comfortable when I'm doing this. If I'm in a position I guess, I don't know, that I don't want to be in, I'm going to take offence to that. But I can understand his standpoint, where he wants me to be in the most, the safest position that's most comfortable for him because he has a job to do. I can understand that. He's the professional. I've never done this before so I trust his judgement. But I'd still like to be able to squat if I want to [*Emily, 39 weeks*] (page 13).

During the birth process, the professionals were seen to have a "job to do" and it was the birthing woman's responsibility to acquiesce and let them get on with the job in a way that was comfortable for them. As Emily points out, the birthing woman would be repaid for her acquiescence: complying with the dictates of the medical and nursing staff was seen to enhance the safety of the birth. The research participants recognized that their own comfort was an important issue, but like Emily did not envision that increasing their own comfort would be positively connected to safety.

Metaphorically, the hospital setting and the hospital staff were envisioned as providing a safety net into which the tight-rope-walking labouring woman could fall if she slipped. The research participants were "scared" at the prospect of traversing this "unknown" territory and they looked to the hospital staff to provide them with the guidance, support and the technical skills necessary to keep them on the tight-rope. There was no expectation that the hospital staff would build them a three-foot-wide plank to traverse instead. Least of all could most of them envision that the holders of the safety net would reach up and ensnare their feet as they made their way across the tight-rope. The very few who did envision this possibility intended to protect themselves with the armour of well informed, assertive, support people. Whatever the strategy, all of the women intended to use hospitals and

physicians as a safety net in case the birth process went awry.

Additional Labour Support

Almost half the research participants seriously considered hiring a midwife or other labour support person to accompany them to the hospital. These women were aware that they could have both a hospital birth and a midwife, and knew that midwifery and home birth were not synonymous terms. The research participants who were encouraged by family members to consider this option gave very clear descriptions of the role an additional support person plays. As Liona's and Penny's narratives indicate, however, both these women rejected the option of hiring a midwife in favour of having their husbands be their sole support person.

> [My husband's sister] said it's just a very nice thing to have someone there who stays with you all the time because the nurses don't, and maybe your husband doesn't know that much about it, who knows exactly what's happening and how to deal with certain circumstances or you know emotions or that kind of thing. And someone who will kind of guide you through the whole process and knows exactly what to do and when to do it and that kind of thing. And that sounds good to me. But you know, I'm happy with my husband to do it [*Liona, 34 weeks*] (page 11).

> Well, my mom doesn't like this that I don't want to have a midwife. Midwives I think tend to do things with a lot less intervention and most of them being women I think they have a little bit more compassion. I guess the main disadvantage right now is that they're not really fully legalized and you can't have one in the hospital with you other than just as a labour coach, which is no different from having my husband there. I think if they were legalized and they were in a hospital setting I would consider going with a midwife [*Penny, 35 weeks*] (page 10).

In contrast to Liona and Penny, Andrea and Caroline evaluated a midwife's services in terms of her knowledge of birth, and her ability to give a second opinion in the event an intervention was suggested. In both these cases, the midwife was seen to play the role of advocate as well as the

role of support person. Andrea, like Liona and Penny, rejected the idea of hiring a midwife, whereas Caroline was still seriously considering either bringing a midwife with her to the hospital or giving birth at home.

> I have heard of people who have hired a midwife and they had a hospital delivery and say that they would rather do that. The doctor would do a general procedure and the midwife would say, "What are you doing? You don't have to do it like that." They get two sides to the, like just hearing one doctor say, "This is how it's done," and you don't know any better. You're following your doctor and you only get another opinion, so it would be good to have a midwife. A disadvantage to that would be, she didn't know what she was doing? most of them do, I don't really see a disadvantage to having a midwife around [*Andrea, 38 weeks*] (page 13).

> I've been toying quite strongly with the idea of a midwife, or at least labour support...I don't want to leave that up to [my husband] because I don't think that would be really fair and I don't think, he would certainly be able to support me but he won't have any idea about the hospital or their policies or doctors or anything more about the process probably than I would know...But I suppose I have a little bit of distrust, things I've heard about hospitals, policy, it's not that they don't have your best interests at heart, however from what I hear is that the most expedient thing is the way they'll go and you won't be informed. That's just, I don't know if that's the truth but that's what I hear over and over - if you don't know to ask for certain things, if you don't know what you can have or what you can request then you're in a pretty vulnerable position. I don't know how my interests, I don't know necessarily that they'll be taken care of in the way that I might wish and the labour support, if it's a midwife, they're more aware of what's going on and know what to ask for me, and that my interests would be taken care of... I just don't want to have non-existent nurses popping their head in, and having different faces, now and again. I just, I just feel like I want the support there so that you just don't have that stress [*Caroline, 18 weeks*] (page 2).

There was a very high rate of awareness of the alternatives of midwifery and home birth, simply because this city has had a domiciliary midwifery practice since the late 1970's and news of this alternative has been spread through word of mouth. These alternatives were not considered to be feasible however, because home birth and midwifery practice were

classified as being incapable of providing a safety net, in contrast to hospitals and medical practice.

The Physical Sensations of Labour

The research participants ascribed negative value to the physical sensations women experience in labour and used the term "pain" to describe these sensations. Either or both of the metaphors of injury (such as a broken bone) or of menstrual cramps were cited as comparisons to the experience of pain in childbirth. The women also tended to categorize their own "pain tolerance" according to a high-low scale. Four of five research participants who defined themselves as athletic, also adopted part of the athletic metaphor to their view of childbirth pain. The athletic metaphor did not supplant the negative meaning of pain, but rather increased their confidence that they could "get through" labour by using the same mental strategies they used in athletics. Other women employed the sports metaphor when speaking of labour and birth as being a "hurdle" [*Becky, 26 weeks*] (page 1) one had to get over, or when speaking of prenatal exercises as being like "warming up for a volleyball game" [*Jackie*, 35 weeks] (page 21). The sports metaphor appears elsewhere, as when the husband/partner is deemed to be the "coach" equipped with a stop-watch to time contractions.

The extent to which the research participants adopted the sports metaphor to their idea of pain in childbirth is exemplified by the quote below. Early in the interview I asked Emily, as I did all the research participants, if there was anything in her experience to which she could compare the experience of pain in childbirth:

> Well I've never had a broken bone or anything like that pain wise, I don't know, I don't really have the greatest pain tolerance either. I fell down once on my elbow and passed out. But, gee, I don't know, everyone just says it's like menstrual cramps only ten times as worse so I imagine it's going to be a lot of you know contractions and stretching and pain like that, burning [*Emily, 39 weeks*] (page 2).

Later in the interview Emily mentioned that she had been a marathon runner, and I followed up on this lead:

> *Laurie: Can you describe what that experience is like? How does your body feel at that time?*
> Exhausted. You start out running, most of my runs are ten mile runs that I used to do and I ran for about, oh gee, about six years. I did a lot of running and was really into running and very compulsive about it and felt quite wonderful. It was very good for my body, very good for my mind and all that and it was a big concentration, it was a big mind over matter and you go through different stages through each part of the run. I mean the first part, you're just getting going, half-way through you may feel like you're going to die, then you know you get sort of a kick-in and your adrenaline and your endorphins and everything and just give 'er near the end. And like, each run is pretty much different but it's a big mind thing [*Emily, 39 weeks*] (page 17).

Like most of the athletic women, Emily's comparison of the experience of birth to the experience of athletics was always implicit rather than conscious. She spoke of "having to concentrate," of birth being "mind over matter," and of her expectation that her endorphins would "kick-in" during labour. Emily's classification of herself as having a low pain tolerance indicates that pain tolerance was not a factor in her marathon runs but was anticipated to be a factor in childbirth. There was no parallel drawn between her bodily sensations experienced while running (muscle fatigue) and the bodily sensations she anticipated during labour and birth. Emily described herself as feeling "wonderful" while engaged in her athletic feat, and although she used the metaphor of pathology to describe the experience of pain associated with muscle fatigue ("you may feel like you're going to die"), this metaphor carries positive connotations: because the experience is painful, it is worthwhile, it is an accomplishment.

In Emily's narrative one notices that both the process of running and the completion of the run are valued. Yet in the research participants' view of childbirth, the process of labour (the portion of the birth experience over which they retained dominion) was devalued. In the women's perception,

as soon as the "product" appeared, the process would be (thankfully) "forgotten." Part of this concept may derive from the form of the birth event. The labour itself is not important enough to require the presence of qualified attendants. Indeed, until labour is established, there is no requirement for the labouring woman to move to the hospital setting. Once she has arrived at the hospital, qualified nurses merely "pop in" intermittently; they do not attend the labour. When birth is imminent, the high-status attendants join the event. In its form, then, the birth event is segmented and differentially valued in relation to the status of the individuals in attendance during each segment. In other words, the structure of the birth event suggests that although metaphorically the pain of childbirth is connected to pathology (it requires hospitalization), the pain is normal enough to be left in the hands of lay people (it does not warrant intensive medical attention).

Although the research participants ascribed negative value to the experience of pain, they nevertheless considered pain to be a "normal" feature of childbirth. Some of them felt that the experience of pain in childbirth could have positive ramifications such as making them stronger people, building their character, and teaching them about themselves and their abilities. Other research participants felt that there was no advantage to be gained from experiencing pain; one just had to accept pain as a normal and inevitable part of childbirth. As Andrea pointed out:

> Advantages to experiencing pain? I don't know. I guess it's just part of the delivery but I can't, it's normal, I mean if you didn't experience the pain, it wouldn't be normal [*Andrea, 38 weeks*] (page 12).

The research participants' statements suggested that the ability to cope with labour was seen as a function of the length of time the labour lasted. Short labours were categorized as "easy" whereas long labours were often categorized as "horror stories." If a woman's labour lasted too long, "help"

in the form of drugs were expected to be given to "speed the labour up." If a woman could no longer cope with labour, she could request, or would be offered, pain medication to "help" her cope. Such "help" would be desirable because having to cope with pain over a long period was seen as being both undesirable and unnecessary. The women did not intend to seek "help" unless it became necessary, although a few of them felt that it would be necessary in their cases. Lynne's remarks on this issue are typical of the way the research participants envisioned their needs during labour:

> The only thing I can think of is if a person's in a lot of pain and they can't do what they need to be doing, sometimes I think [pain medication] might help. If I'm finding that I'm in a lot of pain and I can't push any more or it's too hard and I do need the help, maybe there, I can see with anything, any kind of medication there's probably advantages to it. But as I've talked with everyone, the first goal always is to just go natural and then you go from there. And that's my goal to try and be as natural as possible without any medication. I'd like to do it with no medications, no needles, straight through if I can; no complications, no forceps, no machines, just do it if I can. That's my definition of natural [*Lynne, 14 weeks*] (page 11).

Normal/Natural Birth

When the research participants were asked to describe the experience of birth, they occasionally mentioned the possibility of having pain medication, episiotomy or caesarean section (three women), or more frequently stated that they "hoped" interventions would not be necessary for them (five women). The remaining women did not mention interventions at all when they described what birth would be like for them. Similarly, when they described their ideal births, eighteen of the women did not mention interventions at all, and the remaining six explicitly stated that the performance of one or more interventions would detract from their ideal birth. The women's views on the meaning the "natural" birth are represented in the following quotes:

> It's a natural happy process. I think that that's all that you really, I mean if you know nothing else, if you know at least that this is natural, this happens and is happening the way it's supposed to happen, and it's a happy experience, I think that if that's all you even knew, you could just tell yourself that and things would be fine [*Catherine, 9 weeks*] (page 14).

> [To me natural birth means] to have the baby come out on it's own without being induced or without a c-section, with minimal help from, I guess with minimum medical help, not minimal help from someone else helping but, I guess medical interception (sic) [*Vicki, 22 weeks*] (page 15).

> Our society has turned it into far too much of a medical affair, I think...I'm not saying that it's something that should not take place with doctors in the hospital but I think they have to recognize that it's a natural thing, that they can't always control the way it's going to go. I think there's a return to the more natural ways of doing things [*Penny, 35 weeks*] (page 19).

Although the research participants clearly considered childbirth to be "natural" and "normal," they also defined "natural within set boundaries. Almost all the research participants described 42 weeks as the absolute outer limit of gestation. Many of the women stressed that the inevitable complications associated with being "overdue" justified induction or caesarean section as methods of ending the pregnancy. As the following quotes demonstrate, the research participants endorsed the practice of terminating what they considered to be an overly long pregnancy:

> I think I would be consulting with my doctor before then. I don't think I'd be waiting that long. I think my doctor knows my due date, and I think we'd be taking it [*Lynne, 14 weeks*] (page 14).

> At that point I'm sure they'd be performing a caesarean or inducing the baby to bring it on a little sooner. Or to speed it up if it's gone that far past [*Jane, 21 weeks*] (page 5).

> I'm due the 17th, probably around the 20th, I'm not a very patient person, so probably around the 18th actually, but I would wait probably around the 20th the 25th, somewhere in there of February and I'd go to the doctor and say, "Why?" and I might ask to be induced then. I don't know that my doctor would do it he's sort of a "It's just a natural thing and

> it'll happen when it happens kind of thing," but I would kind of rather it didn't keep going on. For one reason, I don't want the baby to be ten pounds when it's born because it can grow so much inside but another thing I think, you know, you're expecting it at this date, if it's not there, well O.K., a couple more days and it's not there well, you know you're getting really curious and tired you know, you want this baby, and I'd just be really antsy to have it over with [*Donna, 34 weeks*] (page 16).

This set of quotes appears to contradict the research participants' concept of childbirth as a "natural" phenomenon. If the underlying assumption is that childbirth is "natural," then one would expect that the onset of labour would occur in its own time. The research participants had learned a clearly defined set of limits with regard to the length of pregnancy; if a pregnancy were to exceed those limits, this was taken as evidence that something had "gone wrong," it was not taken as evidence that the limits placed on pregnancy might be in error. The research participants also "knew" that the limits placed around pregnancy had been developed through medical research, and it was taken for granted that their physicians "knew" this as well. The research participants therefore trusted that their physicians would perform an induction no later than forty weeks after conception. Under these circumstances one wonders whether a physician would be able to deny a woman's request for an induction if she were two weeks "overdue."

The Risks and Benefits of Interventions

Whereas the research participants learned about the options of midwifery, labour support and home birth from other women, they were more likely to learn about the risks of interventions through reading. The research participants who had read defensive model material had a much greater awareness than the other women of both the risks and the benefits of various interventions. Those who had been exposed to defensive model material via other means than reading (through

friends, family, prenatal class or university courses) were, with one exception, no more or less aware of the risks of interventions than women who had not been exposed to defensive model material at all.[2] The research participants who had read defensive model material were more apt to describe the risks entailed with each intervention and to point out the lack of necessity for using interventions. Those who had not read defensive model material more frequently felt that interventions were conducted only when it was necessary. The following sets of quotes exhibit differences in the research participants' evaluations of the use of interventions. The first quotation in each section was selected from those women who had attended prenatal classes; the second was selected from those women who had not attended prenatal classes; and the third was selected from those women who had read defensive model material.

Episiotomy

Almost all research participants had heard or read opposing views concerning the benefits of episiotomy to prevent tearing of the perineal tissue. A few of the research participants, primarily, but not always, those who had read defensive model material, also spoke of the potential for avoiding tears and episiotomies altogether. These women did not see the issue in either/or terms, but rather knew that there were alternative practices which could be used to prevent both tearing and episiotomy. None of women in this study wanted to tear or have an episiotomy, but most of them had resigned themselves to the probability that perineal damage of some sort was an inevitable part of birth.

Of all the possible interventions the research participants could have focused on for discussion with their birth practitioners, episiotomy was most frequently singled out as a topic of discussion. Episiotomy was not something over which they felt they had absolute control; they felt they

could express their preference to their practitioners, but in the end they considered that it was up to the practitioner to decide whether or not there was "enough room." The three quotes below illustrate typical evaluations of the controversy over episiotomy.

> Episiotomy is where they make the cut, or it could be torn to accommodate the baby coming through because maybe it's too tight and they need more room. So the doctor will either cut it, snip it, or it'll just tear on it's own [*Jane, 21 weeks; has completed prenatal classes*] (page 9).

> That's just when they cut the opening, I'm not sure how much down so that you've got a larger area so that you can get the baby out. And I've heard, well I think that they do freeze it, I'm pretty sure they freeze it, and but my sister, we were talking about not really feeling it when they do it, they must have froze her, and then, well they stitch it all up after, and then I remember her talking about, I don't know, I keep getting confused between my sister and my cousin, they both talk a lot about it, about the pain from the stitches and everything afterwards, quite annoying. And what was it, I can't remember if it was my sister or my cousin but on one of them they didn't have time to do one on another one of the children and they ended up tearing and it seems to me, now I was going to ask those guys later, that was something I wanted to get clear but, it seems to me that they said it actually healed better, they actually were happier when it tore than when, and that's something that I'm going to make sure that I ask them when the time rolls around so that I'm not quite sure if I've got that story right or not [*Janice, 25 weeks: has not attended prenatal classes*] (page 13).

> Like an episiotomy as opposed to just tearing or you know using some kind of a salve or something to reduce the chance that you'll tear, which is I think not done much at all in a hospital situation but it's done quite often with midwives. More of a natural, natural birth. And then I've got friends who are on both sides of that. The one who's an obstetrician says, "episiotomy's nothing, it heals really fast, the reason they do it is so that it'll heal right up, it's a clean," whatever, "cut" [*Diane, 8 weeks: has not attended prenatal classes; has read defensive model material*] (page 9).

Induction

Unlike episiotomy, the research participants did not tend to discuss induction or augmentation of labour with their practitioners. Also unlike episiotomy, the women did not conceptualize induction in either/or terms and they did not necessarily consider that the decision to have an induction was out of their control. To the contrary, many of the women described instances in which their peers had insisted on being induced, and some research participants described the circumstances under which they themselves would ask for an induction. Other women felt that if a time came when an induction was suggested they would "probably just go along with it" [*Emily, 38 weeks*] (page 18).

For most research participants, particularly those who had not read defensive model material, induction was a necessary intervention performed at some point past the due date (almost never more than two weeks past the due date). In their framework, the duration of pregnancy should fall somewhere between thirty-six weeks and forty weeks post-conception. The longer the baby stayed in the womb, the bigger it would get, the less "room" the woman would have, and the more difficult her birth would be. In addition to the problem of diminished dimensions, many of the research participants also mentioned the potential for placental insufficiency at more than forty weeks post-conception. For many of these women, inductions and augmentations were considered to be advantageous because they "got pregnancy over with," they "speeded up labour," and the woman could choose the date on which she gave birth.

Almost all research participants knew that an induction or augmentation of labour would change the force of the labour, and could carry a risk to the baby if conducted too soon in the pregnancy. Some of the women had heard stories that inductions were not always effective, and had to be repeatedly performed on successive days. Research partici-

pants who had read, or sometimes otherwise encountered, defensive model material were more sceptical of the efficacy of induction and felt that it could harm them, their babies and/or their birth experiences. For these women, inductions and augmentations were considered to be necessary only under rare conditions. The three quotes below illustrate fairly typical evaluations of induction.

> They talked about using, what is it oxytocin? So that if you're more than seven to ten days overdue, the placenta may be getting old so they have to induce you before the placenta can't support the fetus any more. So they bring on the labour that way. So I've heard again, most people who have that say that the labour is quite fast and furious. But the nurse was saying at prenatals that it's more refined now and it's not the same as it was. It's not as vigourous because they've refined their dosages and they don't need to give you as much now because it's not quite severe as it used to be. And the same with augmenting I gather. If you're not progressing they can use some of the medication to bring things along and get things going into a rhythm more [*Becky, 26 weeks; has attended prenatal classes*] (page 14).

> I have a girl friend who was induced because she wanted her doctor to deliver her baby and he was going on holidays the next day (laugh). So it could be then or she could wait. So she went into the hospital, and she was induced so I believe that they just broke her water (snaps fingers) and then just waited for the labour process to start because of course there were no contractions or anything, you know, so...I suppose there is an advantage to being induced because you can pick when you want to deliver the baby (chuckle), as in the case of my girl friend, if you wanted to have it sooner. A disadvantage, I suppose, I don't think there's really any disadvantage except for the fact, I mean a doctor certainly wouldn't induce unless there was some sort of medical problem or something [*Anna, 20 weeks: has not attended prenatal classes*] (page 16).

> Like the doctor says, we don't know until it happens. She's not going to make me any guarantees that she's not going to induce me...I don't think an induction is ever necessary either...I don't want to be induced. I think that the baby and my body knows the process it needs to go through. Millions of women over millions of years have been doing this and I mean the rest of the mammal population too. It's a natural process and it'll happen when it's supposed to happen and if you push it I think you're going to harm the baby, most definitely, and possibly me. I don't think there's ever a really, unless the woman is unhealthy, ever a need for an

> induction. I'm not unhealthy, I'm very healthy and I don't think with me particularly that there will ever be an instance in a pregnancy that I would need an induction of that type [*Charmaine, 34 weeks: has attended two prenatal classes; has read defensive model material*] (page 10).

Caesarean Section

Caesarean section was viewed as an undesirable but beneficial intervention as it was seen to be performed only to save the mother's or baby's life. Although many indications for caesarean section were enumerated, the research participants tended to cite the inadequate size of a woman's pelvis as a primary reason for performing a caesarean section. As was the case with episiotomy and with induction performed for an overdue (big) baby, caesarean sections were seen as being required for lack of "room." The research participants felt that the major disadvantage of having a caesarean section was that a woman would miss the natural birth she had prepared for, it would be more difficult to recover from both surgery and birth, and the woman would be left with a scar. Some of the women felt that although not desirable, caesarean section would be easier than vaginal birth and that the baby would be a better quality (have a rounder head and look better).

The research participants who had read the defensive model material were not convinced that caesarean section was necessarily beneficial unless it was absolutely necessary. To reinforce their arguments, they indicated that surgery could be harmful to the baby, particularly because they viewed the process of labour as having beneficial physiologic effects on the baby's lungs. Most of the research participants were aware of the controversy over the increased rate of caesarean sections, and felt that some physicians (particularly if the physicians were not Canadian) were "cut happy." The three quotes below illustrate typical evaluations of the controversy over caesarean sections.

The book I've read, the books What to Expect When You're Expecting and the film, they perform a caesarean when a natural birth is not feasible because of breech or something that would either harm you or the baby so they cut you open. But it's a, it's come a long way. They cut you this way under here [gestures] or right up there. The husband can be in through it all if he wants and, let me think. The advantages to that, well there's no, if your baby's in trouble in distress you know, you don't want to harm your baby, that's an advantage. I know that I did watch a program, where, it was from the States, where the doctors were doing it because they make more money doing it and it was more convenient, and quicker, you know. The woman books in for a caesarean, she gets it done and that's it, eh? But I was, the doctors here don't, well the doctor we spoke with, our doctor says no, they don't do it unless it's absolutely necessary [*Jackie, 35 weeks: has completed defensive model prenatal classes*] (page 15).

Sometimes if you don't have a big enough pelvic area and the baby can't be born through the normal birth canal, they have to do the c-section. And [a good friend of my dad's] had to have a c-section for both of her deliveries. And sometimes doctors have commented to these particular women, to this particular woman that if she's had trouble with her first birth and she had to have a c-section sometimes what they do is they don't recommend another pregnancy if you're, if you had some complications with your first. My mom was telling me that by looking at my hips and my pelvic area she said, "No problem there, you won't have to have a c-section. I didn't have to." But sometimes if there's also complications, if there's going to be some harm caused to the mother as well as the baby, what they'll do is a c-section as well [*Kim, 8 weeks: has not attended prenatal classes*] (page 8).

Well it's just too common that they tend to be given because the doctors want to be sure, they want to guarantee that everything is going to be fine. So there's failure to progress, two hours or two and a half hours or whatever time they allot you to have it naturally, if you haven't, then they say, "Well, failure to progress." And especially if its a large baby, when they're not sure this baby can pass the pelvis. But basically it's not the best thing because when the baby comes down the actual process of labour for one hours or two hours helps to squeeze out excess fluid in the lungs [*Yvonne, 27 weeks: has not attended prenatal classes; has read defensive model material*] (page 8).

Pain Medication

In contrast to the almost overwhelming acceptance of the necessity for other interventions in childbirth, most of the research participants considered the use of pain medication to be undesirable and (hopefully) unnecessary during their particular labours. Almost all research participants knew that analgesics and anaesthetics can have harmful effects on the baby, but the harm that could result from the use of pain medication was almost always emphasized by those women who had not read defensive model material. In contrast, those who had read defensive model material were more likely to enumerate the ways in which pain medication could interfere with their experience of childbirth.

None of the research participants ruled out the possibility that they might require pain medication to help them "get through," and some of the research participants were resigned to the probability that they would require medication. When considering the use of pain medication, most of the women felt that this was an intervention over which they had control. Recognizing it as their own decision, the women were most interested in learning about the various types of pain medication so that they could make an informed decision (sometimes in consultation with their husbands or partners) about the type of medication to use if and when the time came. Most research participants nevertheless intended to prevent the probability of their requirement for pain medication. Their various strategies for relieving pain without medication included: envisioning a short period of labour; repeating positive affirmations; learning breathing and relaxation techniques; bringing music and/or relaxation tapes with them to the hospital; bringing perfume to change the scent of the air in the hospital room; bringing their own bedclothes to the hospital; and bringing an extra labour support person (in addition to their husband/partner) who could alleviate pain through massage, therapeutic touch, or acupuncture. The three

quotes below illustrate typical evaluations of the use of pain medication in labour.

> I think it's totally a matter of personal need. Some people handle pain a lot better than others. As far as disadvantages go, I guess if you had morphine the baby could be born quite sleepy and require some drugs to counteract that. But I don't really see a disadvantage with pain medication or pain control [*Penny, 34 weeks; has completed prenatal classes*] (page 10).

> I guess sort of generally I could say, before I decided I would need to know what effect this is going to have on my baby before I take the medication. You know, is this going to be something that just takes, takes away the pain or is it going to facilitate the delivery as well and maybe those are tied together, who knows? So I think primary in my mind would be, you know is the baby going to be harmed? What are the chances? Because, I mean people take pain medication as adults on a regular basis and you know I trust that my body, you know would be able to deal with it. But we're talking about a very different situation for an infant [*Catherine, 9 weeks: has attended early bird class only*] (page 9).

> I've read about all the pain medications...there's a gas you can take. The things I've read about it is that it affects your baby whether they [prenatal class teacher] tell you it doesn't affect your baby, it does. Like you know, one book I read talked about if you take I don't know what kind of drug it was, demerol or I don't know there's so many different names, but you know your baby could be born really limp and half drugged out and you know everything that you did was just sort of a blur, and you know I want the experience to be really crisp in my head, I want to remember it, I want the baby to be alert and I don't want it when it can't breathe because it's half drugged. And then there's epidural where they're "Oh yeah, get that for sure. It's great, it's wonderful." It sounds really nice (sarcastically) a needle up the spine wondering if you're going to feel your legs again. "Go for it, yeah." I don't want it you know. Like I say, a lot of women have said it's wonderful, it takes all the pain away but I don't want to have no feeling from the waist down. I want to be able to feel the baby come out. One girlfriend I talked to said it was the most wonderful feeling to have a baby come out of you, you know, and I want to be able to feel that. I don't want to be numb from the waist down. So I'm hoping I can withstand the pain and be able to feel it [*Andrea, 38 weeks: has completed prenatal classes; has read defensive model material*] (page 10).

Clearly the research participants differed in their evaluations of the risks and benefits of several common

interventions used in childbirth, but this was the only patterned variation detected in the data. Those research participants who had not read defensive model material were less well versed in the possible alternatives to episiotomy, and the possible harmful ramifications of induction and caesarean section. Almost all research participants knew that pain medication could have harmful effects on their babies and on themselves, yet they all also knew numerous women who had taken pain medication and suffered no deleterious effects. Furthermore, the willingness of health care professionals to use drugs indicated that drugs must be relatively safe. As Laura stated: "I'm sure it wouldn't be that harmful if they were giving the drugs to the ladies" [*Laura, 5 weeks*] (page 10).

Because the women had been "healthy all their lives" or "healthy during pregnancy," they tended to discount the possibility that interventions would be necessary for them. Diane, Liona and Donna had different perspectives on this issue, but together their narratives provide fairly representative examples of the research participants' views:

> I think there's just less and less patience or there has been less and less patience to allow births to happen in hospital situations because people are pressed to do all this fancy stuff and really delivering a baby should involve just a lot of waiting and then a lot of coaching and then just catching the baby. I mean there's, people have been doing it for millions and millions of years and obstetrics is relatively new so, it seems like the, that's what we're looking for. Someone in a hospital setting who has the patience and is on our wave length who isn't inclined to force things unless there's some real reason for it [*Diane, 8 weeks*] (page 14).

> The most important thing that I already know, I think that most women make it through...For most women things go pretty well, you know the baby is head down and facing the proper way and the umbilical cord doesn't get tangled around anything and you know that kind of thing. Most of the time everything goes the way it should go. And usually I'm in the most category. [*Liona, 34 weeks*] (page 20).

> Mine will be individual from anybody else's. I think that's important to know. Maybe better than some, maybe worse than

> some. And another thing that I guess is important is that, well, I trust my doctor and I know that if he's going to do something it's for a reason, and I may not need to know what that reason is but if it's being done it's not, he's not a new wave kind of guy, he's older and he's traditional and birth is natural, and don't get worried about it just do it. And that's perfect for me. So I trust him and that's important [*Donna, 34 weeks*] (page 21).

Trusting the Birth Practitioner

Although clearly most of the research participants trusted their own physicians, it was not unusual for them to express some cynicism of physicians collectively. For those women who had been unable to develop good relationships with their practitioners, this evidence was extrapolated and applied to the demeanour of "doctors" in general. Almost all the research participants, whether or not they had developed good relationships with their practitioners, expressed their doubts about whether their physicians would actually attend the birth. Again, "doctors" were known to "not always make it on time," and the women hoped that this would not happen to them. They worried that they would feel uncomfortable with a strange physician, and stated they would be annoyed if their own physicians were not present, but they did not have any worries that another physician might have a different standard of practice regarding the performance or non-performance of interventions. This was true even though many of the women remarked that "doctors" routinely intervene or noted that "different doctors believe in different things" [*Lynne, 14 weeks*] (page 15).

There are data which suggest that the research participants' perception of physicians collectively was rarely taken into consideration when interpreting the practices of their own physicians. This is particularly glaring in Janice's and Ellen's cases, both of whom had regarded "doctors" with some cynicism (Janice had described obstetricians as being "cut happy for caesareans" (page 20)). Even though each of these

women was critical of the over-zealousness of "doctors," their judgement of their own physicians was unaffected by evidence that their physicians tended to intervene. The situation was slightly different in Charmaine's case. She had recently fired her obstetrician (whom she felt was cold, uncommunicative and likely to intervene) and hired a new obstetrician who was "easier to talk to." Charmaine noted that her new obstetrician was "kind of vague" (p. 3) when she discussed interventions, but unlike the previous obstetrician, she was at least willing to discuss the issues.

> She said that the problem with short women like me and her was that we could not bear the child ourselves because it wouldn't fit through the pelvic bones. It was just too tight to squeeze. They had to cut it out...The reason she told me was I said to her, "As it stands right now, do you see any indications of me needing a caesarean? Is there any problems yet that would indicate that I might possibly need a caesarean?" Because her caesarean rate is, I think she said 21%. It seems really high to me. I mean I know that's about average for the country but it just seems really high to me. Unless she gets a lot of problem patients, high-risk pregnancies, very old, very young girls, I can't see it being that high or need to be that high unless she's over zealous in the first place to do the caesareans. And the reason I asked her is because she said 20% and I thought, "Oh well, what is she going to do to me then? Do you think I need one?" kind of thing. I don't know, I don't put much merit in her explanation of because I'm short I won't be able to push this baby out [*Charmaine, 34 weeks*] (page 14).

> What is it my doctor said to me now when I asked him about does he do episiotomies?..I believe he said, "Well he would do an episiotomy because he would get paid to stitch you up that way but if you tore he wouldn't get paid." I think that's the way he put it [*Ellen, 20 weeks*] (page 8).

> I ran into a lady at the doctor's office yesterday that I overheard her talking to the receptionist and she said "Well I'm going in to have the baby tomorrow." So I ended up having a chat with her and she said she was being induced tomorrow. I was asking her if she was getting a caesarean and she said induced. I said, "Oh are you overdue?" And she said,"No I'm not overdue yet but they say the baby is big enough that we can go ahead with it." And she said she's just had enough, the baby's active and [the doctor] said that they could go ahead and induce her and get things going...I mean I was quite surprised when I heard that lady yesterday saying that she was

> going to do it and she wasn't past her due date or anything, that she just wouldn't wait and see what was going to happen. I could see after a couple of weeks, being overdue that they might want to just get things going because you wouldn't want anything to go wrong [*Janice, 25 weeks*] (pages 15 & 17).

Although Charmaine valued her obstetrician's willingness to discuss interventions, she nevertheless remained sceptical of her style of practice. She disagreed with her obstetrician's assessment of her potential need for a caesarean section, but she did not intend to confront her obstetrician unless the issue arose during labour. This contrasts with Ellen's evaluation of her obstetrician's frank discussion of his style of practice. Ellen categorized an episiotomy as being better than a tear, therefore the information that her physician will only "get paid" to stitch up an episiotomy had no bearing on the issue. If he had to "stitch her up" anyway, why should he not be paid for it? Janice, on the other hand, had learned through her physician's treatment of episodes of bleeding in early pregnancy that her physician is both "conscientious" and "over-cautious" (page 20). Given this categorization, it was difficult to reconcile the information that her physician agreed to induce a woman without a clear medical indication. Janice knew that her physician was going to perform an early induction, but as she assessed the situation, the responsibility for this action rested not with the physician but with the woman who requested the induction.

Many of the research participants made it clear that they were less accepting of errors of omission (failure to intervene) than they were of errors of commission (intervening too often or too soon). When the women recounted the birth stories they had heard, they tended to condemn those birth practitioners who "let" a woman labour too long, who did not perform a caesarean section soon enough, or under whose care a woman had experienced a large perineal tear. Such cases were categorized as evidence of professional incompetence. Rarely were birth practitioners condemned for intervening too

often or too soon unless such birth practitioners were citizens of another country ("the States") or another time ("back then"). Errors of commission were seen to occur when practitioners were motivated by greed or convenience ("the States") or when practitioners lacked the necessary knowledge and skills ("back then" or "interns"). The women did not consider their practitioners to be either greedy or unknowledgeable, and therefore errors of commission were not expected to occur. As Laura put it, "He's a very understanding person and I have good conversations so you know if it wasn't necessary then he wouldn't do it" [*Laura, 5 weeks*] (page 10).

The Credibility of Information

Although mentors were always considered to be credible people, the research participants did not give much credence to the information they had obtained from their other friends and acquaintances. The women noted that they tended to hear "horror" stories, and they dismissed these stories on the grounds that "everybody's different," or on the grounds that the woman who had had a 'bad' experience was in some way different from themselves:

> I always take anything you hear subjectively because she's much younger than I am, she may have been more frightened. Maybe her expectation level would be different than mine. So I'm trying to ignore that fact and continue to believe that the [hospital I'm going to] will be just a fine place for me to deliver in and that how I respond to the nurses is how they're going to respond to me. If I give them a difficult time, yeah, they're going to give me a rough time too. And maybe because for this gal, because she was stressed because there was a complication, she had to deliver some place else, in some place she didn't know away from her family, maybe that's why she has such a negative of it. So I'm trying to ignore it but in the back of my head I'm hoping that all will still go O.K. [*Jane, 21 weeks*] (page 19).

Occasionally the research participants attributed the telling of "horror stories" to women's callousness, but in other cases they perceived that only sensationalized stories

made good copy (either stories in the news media, in television drama, or as told by peers).

> Like I said before, women do it to each other I think. They just start talking about, "Oh," it's like you have to try to top one another about "how horrendous my experience was when I had my child." And it's like why do we have to do that? [*Ellen, 20 weeks*] (page 3).

> Not credible I suppose would be people, men or women who have never had anything to do with a baby but are telling me what to expect because of what their sister or aunt or somebody went through. I don't find that credible at all. Even people with first hand experience that try to sensationalize it I suppose, I don't really take too much notice of [*Donna, 34 weeks*] (page 20).

> [N]ormal childbirth, it doesn't really make headlines. But if there's a problem then I think that's what the newspapers pick up on. And I guess that's news. But I don't think it's, like often in the news you get the feeling that the things they report happening a lot more frequently than they do. So that's kind of, they report the things that people are interested in hearing they don't report just normal everyday birth things [*Liona, 34 weeks*] (page 9).

Women's different characteristics, sensationalism and lack of experience were three criteria which diminished the usefulness of information. Information about birth practices that were non-local or non-contemporary also tended to be dismissed as non-useful. For example, only two of the women who talked about water birth knew that this option was available through local midwives. The others accepted the that it was only available in Europe or in "the States." Similarly, some of the women knew much more about midwifery practice in the United States than they did about the local midwifery practice, and they knew about the high caesarean section rate south of the border but not about such rates locally.

In contrast, the information contained in pregnancy manuals was thought to be more reliable, even though as some research participants suggested, they would "take everything [they] read with a grain of salt" [*Janice, 25 weeks*] (page 10). Information obtained from prenatal teachers and from

hospital tours was also valued. Occasionally this information conflicted with information contained in books, and in some cases conflicting evidence devalued the prenatal education material but in other cases it did not. Finally, the research participants considered their practitioners and/or their practitioners' nurses to give credible information. When this was not the case, the women sought out a new practitioner. The value of information increased when the transmitter possessed professional health care credentials (whether or not those credentials were related to 'childbirth'). Professional credentials, however, were not enough to establish reliability. Rather, there is good evidence to suggest that the women's affinity for the transmitter was an equally important factor affecting the value of information transmitted.

Summary of Findings

The lack of variation between the research participants' descriptions of childbirth suggests that the women had learned the same cultural script. The data further suggests that the cultural script was learned through informal networks and was confirmed and reinforced through formal means during pregnancy. Therefore, despite having low credibility, knowledge acquired through informal means appeared to have the highest functional value in shaping women's concept of childbirth. In other words, the women's concepts of childbirth did not depend on whether they were in early, middle, or late pregnancy, although the confidence with which they held these concepts was enhanced in late pregnancy. Finally, if the women in early pregnancy had learned the same cultural script as those in later pregnancy, and if their available learning time (as has been shown) was severely limited, it would suggest that much of what is learned about childbirth is learned prior to pregnancy.

Prior to pregnancy, much of what the study research participants came to know about childbirth was acquired

opportunistically, although occasionally the women purposefully pursued childbirth knowledge as well. But whether they obtained their knowledge through passive absorption or active pursuit, for the most part the knowledge was stored away whole, in undigested form, to be recovered at a time when they would find it useful; that is, a time when it would have some applicability to themselves. Although the research participants tended to dismiss this phase of cultural transmission, it was nevertheless extremely important because the undigested, accepted knowledge formed the foundation on which their ideas of childbirth were built.

During pregnancy, the research participants tended to purposefully pursue childbirth knowledge and people around them tended to actively transmit childbirth knowledge. The knowledge encountered during this period was much more likely to be digested or thought about in terms of its applicability to themselves and in terms of the foundation of knowledge they had acquired prior to pregnancy. Much of what was learned during pregnancy either confirmed what the women already knew, or very often, it gave definition and clarity to their previously half-formed concepts. When asked whether they had ever come across anything about childbirth that was novel, that surprised them or that they did not know previously, most research participants could not name anything. This does not mean that women did not acquire knowledge during pregnancy, but it suggests that much of what was learned fitted with their pre-formed perceptions of what birth was all about.

Notes to Chapter IV

1)

TABLE IV Listing of Research Participants' Reading Material

NAME	READING MATERIAL	ACTIVE ACQUISITION	PASSIVE ACQUISITION	FURTHER VALIDATION
Laura 5 weeks	What to Expect When You're Expecting Information from doctor's office		Will get from sister physician	
Diane 8 weeks	What to Expect When You're Expecting The Well Pregnancy Book Assorted Library Books Our Bodies Ourselves	purchased library read as teenager	 physician admonished	
Kim 8 weeks	The Complete Book of Pregnancy and Childbirth, S. Kitzinger Book from doctor's office Browsed through numerous books	 library	gift from husband physician	
Catherine 9 weeks	The Complete Guide to Motherhood and Childbirth, C.M.A. American Publication with similar title Textbook of Embryology	purchased University		
Lynne 14 weeks	Complete Pregnancy Workbook Having a Baby Living With Baby in Edmonton and Area Pamphlets and Promotional Material from Welcome Wagon	purchased library	 Welcome Wagon	
Geri 15 weeks	What to Expect When You're Expecting Book about Baby Care		given by sister given by sister-in-law	physician
Caroline 18 weeks	Secret Life of the Unborn Child Numerous library books	library		
Käthe 19 weeks	A New Life Information from ASAC	? contacted		mother
Anna 20 weeks	What to Expect When You're Expecting The Pregnancy Diary The Miracle of Birth *Great Expectations*	?	 physician's office	
Ellen 20 weeks	Skimmed through Gentle Birth, Leboyer Skimmed through book about high risk pregnancy Magazines in doctor's office	library library	 physician's office	
Michele 20 weeks	The Complete Book of Pregnancy and Childbirth, S. Kitzinger	purchased		
Jane 21 weeks	What to Expect When You're Expecting Browsed through books at the book store; asked for recommendation from a pregnant woman in the store	 book store	given by friend	physician stranger
Vicki 22 weeks	What to Expect When You're Expecting Text book about Child Development	purchased University		friend

NAME	READING MATERIAL	ACTIVE ACQUISITION	PASSIVE ACQUISITION	FURTHER VALIDATION
Janice 25 weeks	Books about development, nutrition, hazards of pregnancy, Book about childbirth, Book about Baby Care Pamphlet about Circumcision	purchased	 given by sister given by physician	
Becky 26 weeks	What to Expect When You're Expecting Book on the Lamaze Method Your Pregnancy Companion Some books from library	 purchased library	given by sister given by sister	
Yvonne 27 weeks	The Complete Book of Pregnancy and Childbirth, S. Kitzinger Having a Baby Living With Baby in Edmonton and Area A Midwife's Story A Wise Birth Information from ASAC	 Library Library Library contacted		
Charmaine 34 weeks	Our Bodies Ourselves Methods of Childbirth, C. Bain Gentle Birth, Leboyer Numerous other Library Books I Don't Want to Live This Life	 Library Library Library Library - read first as teen	given by friend	
Liona 34 weeks	Pamphlets from Board of Health Pamphlets & promotional material from Welcome Wagon Pamphlets from Prenatal Class		given by mother Welcome Wagon Prenatal Class	
Donna	What to Expect When You're Expecting Great Expectations	purchased		
Penny 35 weeks	Numerous Library books about birth alternatives (drugs)	Library		
Jackie 35 weeks	What to Expect When You're Expecting Your Pregnancy Guide Six Steps to Easier Childbirth Thank You Dr. Lamaze Pamphlets from Prenatal Class		given by boss Welcome Wagon given by sister-in-law given by sister-in-law prenatal class	
Andrea 38 weeks	A Pregnancy Companion: What You Need to Know Before During and After Pregnancy What You Should Know Before You're Pregnant: Hazards and Exercises The Complete Pregnancy Book Pregnancy Work Out Numerous other Library books (some defensive model) Magazines in doctor's office Prenatal class Book about Baby Names	 purchased purchased library library	given by sister physician's office prenatal class given by friend	

NAME	READING MATERIAL	ACTIVE ACQUISITION	PASSIVE ACQUISITION	FURTHER VALIDATION
Emily 39 weeks	Mother's Almanac A New Life A Child is Born Lamaze Method book Prenatal Class numerous library books on nutrition	 library	given by sister-in-law Prenatal Class	2 sisters-in-law
Cheryl 40 weeks	Pregnancy Week By Week Books on Breastfeeding, Lamaze, Baby Names Magazines and Pamphlets from Prenatal Magazines and Pamphlets from Doctor's office	purchased	given by sister-in-law Prenatal physician's office	

2) Although advocates of midwifery and home birth are critical of hospitalized childbirth (Ouwerkerk, 1995; Damsma, 1994), I do not consider them to necessarily subscribe to the defensive model of childbirth education, but rather to the "opting out" model. Defensive model childbirth educators, like Jackie's prenatal teacher or Vicki's university professor, as well as the authors of numerous defensive model books (Korte & Scaer, 1984; Howe Elkins, 1983 & 1985; Brackbill et al., 1984; Feldman, 1978) all recommend that 'consumers' can and should use their power to reform hospitalized childbirth. Women who opt for home birth do not directly challenge the existing system and therefore do not serve the agenda of defensive model childbirth educators.

CHAPTER V - DISCUSSION

Introduction

In the previous chapter I presented evidence which suggested that the research participants did not embark on the journey through pregnancy as blank slates, but rather had already learned a number of 'self-evident truths' which informed their concept of 'childbirth' and which defined the who, what, when, where, why and how of childbirth practice. The cultural values underlying these 'self-evident truths' were implicit in the transmissions of childbirth knowledge; they need not be, and frequently were not, overtly articulated. As the women acquired knowledge during pregnancy, they evaluated that knowledge in relation to the 'self-evident truths' already held. In this chapter, these 'self-evident truths' will be presented and discussed in relation to the findings of this study and in relation to each of the four aspects of the childbirth debate; safety, use of technology, pain and autonomy.

Although numerous researchers have described two opposing cultural views of childbirth (medical versus natural) (Sargent & Stark, 1989; Katz-Rothman, 1991; Davis-Floyd, 1992; Damsma, 1993; Jordan, 1993; Lazarus, 1994; Ouwerkerk, 1995), the data collected in this study suggested to me that while the research participants recognized the existence of the two opposing views, they did not perceive childbirth to be either "medicalized" or "natural." Rather, their complete concept of childbirth was composed of the values underlying both medicalized childbirth and natural childbirth. A discussion of the integrated nature of their concepts of childbirth will demonstrate that the research participants' behaviour was rational in relation to their concepts, particularly with regard to the issues of safety, pain, and the use of technology.

The issue of autonomy, which carries with it both political and moral overtones, will be discussed in relation to the research participants' concepts of childbirth and in relation to the premises underlying the two models of childbirth education. Both forms of childbirth education will be shown to make demands on childbearing women that are partially incompatible with their complete concept of 'childbirth.' The discussion will then turn to an examination of statistics which reveal inconsistencies between actual childbirth practice in Alberta and the research participants' concepts and expectations of childbirth. Finally, several conclusions will be drawn, the limitations of the research will be discussed, and recommendations for further research will be suggested.

Childbirth in Relation to Safety

In her recent book, Birth as an American Rite of Passage, Davis-Floyd (1992:160-161) convincingly argued that the culture surrounding American childbirth is composed of two opposing value systems which she labled the "technocratic" and the "wholistic" (sic) models. Although Davis-Floyd acknowledges that most of her interviewees did not adhere rigidly to one or the other model, she nevertheless provides ample evidence for the co-existence of the opposing models and she distinguishes the models by identifying two sets of mutually exclusive values. For example, Davis-Floyd argues that the "technocratic model" is characterized by a perspective in which childbirth is viewed as "inherently pathological" whereas in the "wholistic model" (sic) childbirth is viewed as "inherently healthy" (Davis-Floyd, 1993:160-161). This polarization is similarly emphasized in two recent local studies, one of which was conducted among Alberta midwives (Ouwerkerk, 1995), and the other of which was conducted among women who engage midwives as their childbirth practitioners (Damsma, 1994). This suggests that midwives and women who

use midwives define themselves and distinguish themselves through an articulated philosophy and style of practice which differs from that of people who, although being part of the same culture, adhere to a more medicalized ideology and practice.

Admittedly, when I began this research project, I had expected to find data which would support, not refute the existence of two opposing views of childbirth. As I was soon to discover however, my preconceived notions were not supported by the data. Rather, I found that the research participants held a integrated concept of pregnancy and childbirth which supported both the holistic/natural view and the technocratic/medical view. This concept is stated below in the form of what I have labled a 'self-evident truth.'

> **The state of pregnancy which culminates in the process of childbirth is a normal, healthy, natural state that is fragile and precarious and could "go wrong" at any moment.**

Like the philosophy of midwifery held by the midwives in Ouwerkerk's study, and like adherents to Davis-Floyd's "wholistic model" (sic), the research participants in my study believed first and foremost that pregnancy and childbirth are normal, healthy and natural, not inherently pathological. The research participants were cautious, however. Even though they knew pregnancy and childbirth were inherently natural processes, they also knew that something could "go wrong." As a consequence, none of them were willing to leave the outcome of their pregnancies and births to the fates and the gods (this might be the true definition of natural childbirth). They knew that the odds were in their favour, but they nevertheless took actions throughout their pregnancies to improve their chances and increase the probability of a safe outcome.

As I argued in the introductory chapter, maintaining the safety of the outcome of pregnancy and birth is a moral goal in this society. To achieve this moral goal, socio-cultural

practices have been instituted whereby there has been an allocation of responsibility for the maintenance of safety. According to Davis-Floyd's analysis, this responsibility is allocated to physicians in the "technocratic model," and to the mother in the "wholistic model" (sic). Furthermore, within the local context (Edmonton), midwives who attend home births distinguish their practice from that of physicians with the claim that it is the pregnant woman herself, not her practitioner, who maintains "responsibility" (Ouwerkerk, 1995).

The question of the location of responsibility therefore appeared to me to be one of the hallmark features which distinguished the two opposing models of childbirth posited to be present in this culture, and because I interviewed women who planned to give birth in hospital, I expected to find that they would allocate responsibility to their practitioners. Indeed, on the symbolic level it appeared that explicit responsibility was assigned to physicians. On the practical level, the level of day-to-day living, I found that the "responsibility" for 'safety' did not rest entirely with practitioners, but rather was shared between the pregnant woman, the members of her community and her practitioner.

Turning to analyses of the patterns of childbirth cross-culturally, I found the suggestion in Mead and Newton (1967:164) that the social processes which mark the allocation of responsibility to the prospective mother (and father, in some cases), is a feature of many cultures (Mead & Newton, 1967:164-169). Therefore, during data analysis I asked a question similar to that posed by Mead and Newton: 'What actions are taken during pregnancy to fulfil culturally prescribed moral goals, and who takes those actions?' I found that the responsibility for maintaining the moral goal, 'safety,' was fulfilled through the actions of the pregnant woman, the actions of the members of her community, and the actions of her practitioner.

The research participants' statements indicated to me that they, not their physicians, held the primary responsibility for maintaining the safety of the pregnancy and birth: they were obligated to do everything in their power to ensure that their pregnancies did not move from the normal to the pathological. One of their first duties was to change their dietary patterns and to regulate their physical actions to ensure that they did not in some way compromise the health of their babies. Although the women knew from the outset of their pregnancies that they were obligated to fulfil this responsibility, it was very frequently the members of their communities, not their physicians, who defined the rules for behaving appropriately.

The members of the research participants' communities assumed the responsibility for transmitting the rules of behaviour. Community members repeatedly offered the pregnant women prescriptive and proscriptive advice and in so doing demonstrated their "feelings of heightened solicitude toward the pregnant woman" (Mead & Newton, 1967:165). They further emphasized behavioral requirements by giving the women books to read which comprehensively outlined the full range of prescriptions and proscriptions. In a carrot and stick approach, this reading material enumerated the potential dire consequences that could result should a woman fail to adjust her behaviour, while at the same time providing assurance that an 'easier' childbirth would ensue for those women willing to comply. In other words, through their actions, community members repeatedly invoked (public knowledge of) medical knowledge to reinforce the idea that pregnant women can damage the health of their babies through their inappropriate behaviour.

The interaction between the research participants and the members of their communities repeatedly reinforced the pregnant women's obligation in relation to safety. Davis-Floyd (1992:22-43) has effectively described this (hazing)

behaviour as one of the rituals that is encompassed within the rite of passage which occurs over the childbearing year. The research participants' physical state 'pregnancy,' was frequently singled out for attention by members of their communities who regularly questioned them about the condition of their health and the progress of their pregnancies ("*How are you feeling?*"). More specific questions regarding the pregnant women's diets, their exercise regimes, their consumption of tobacco, alcohol and medications, their footwear, their driving habits, their bathing patterns, their practice of reaching up to retrieve objects from high places or of lifting minimally heavy objects, etc., all placed the onus for safeguarding the safety of the baby on the pregnant women's shoulders.

The second message implicit in these transmissions is that pregnant women are not considered to be competent adults; like children, they must be supervised and helped to perform the most mundane tasks. The women's reactions to these transmissions ranged from feeling deeply insulted to mildly amused. When Geri remarked, "Don't they know I can do this myself?" (*Geri, 15 weeks*) [page 11) she was rebuking her community for their lack of trust in her abilities. In contrast, when Jackie remarked that she was treated "Like Cinderella almost, as if you could break" [*Jackie, 35 weeks*] (page 6), she was expressing her amusement at what she considered to be the silly behaviour of the people in her community. Jackie knew that labour and birth required strength, not weakness, and she was troubled that the people around her categorized her as weak, or as someone who needed to be rescued.

The actions of both the research participants and the members of their communities can be stated in the form of a second 'self-evident truth' which describes the delegation of responsibility to the pregnant woman for safeguarding the pregnancy in its normal, healthy, natural state:

> **By behaving in a prescribed manner (becoming educated about pregnancy and birth, avoiding harmful foods and activities, and getting the appropriate nourishment and exercise), the pregnant woman can hope to a) improve the quality of her forthcoming labour and b) prevent things "going wrong."**

In addition to the responsibility for modifying her behaviour, the pregnant woman is invested with a second responsibility; she is required to ensure that any abnormality in the pregnancy or birth process is detected. She fulfils this obligation by engaging a qualified practitioner who will monitor the pregnancy and birth (Arney, 1982). This action did not require deliberation; the research participants knew that hiring a practitioner was the "proper" course of action to take. The only questions some of them posed was: Which practitioner should I engage? And, should I engage both a physician and a labour support person/midwife? Perhaps not surprisingly, members of the pregnant women's communities commented on the qualifications of the particular practitioner chosen, and occasionally expressed their disapproval in cases where the woman chose a general practitioner over an obstetrician, when she chose a midwife over a physician, or when she chose a physician over a midwife.

Once the pregnant woman has fulfilled her obligation by engaging a practitioner, the practitioner carries out her/his responsibility by measuring body fluids, measuring body dimensions (internal and external), measuring body noises (heart beat), and measuring electronically generated pictures of the woman's interior (ultrasonography). From these measurements, the practitioner is expected to detect signs of abnormality. Although the explicit responsibility for detecting abnormality appears to be delegated to the practitioner, however, the actions of the pregnant woman and the members of her community suggest that during pregnancy the pregnant woman, her community and her practitioner retain the shared responsibility for detecting abnormality.

To detect such abnormalities, the research participants frequently consulted their books (advice manuals) or turned to their mentors to seek advice about whether or not their sensory experience could be interpreted as "normal." If the pregnant woman or her mentor suspected abnormality, the practitioner was alerted to this prospect during the monthly appointment, or sooner if the suspected abnormality was serious. The mentors were then apprised of the practitioners' judgements about whether the pregnancies were progressing normally. They asked the research participants: *what did your doctor say?* Through this process the mentors effectively monitored (albeit often in lay terms) both the progress of the women's pregnancies and the practitioners' performance in relation to those pregnancies.

Only when a mentor was invited to accompany the woman to the birth chamber was the process of monitoring envisioned as something that would continue beyond the hospital door. In these cases, the research participants expected their mentors to act as advocates, to provide a second opinion and to safeguard against the possibility that an intervention would be performed unnecessarily. Otherwise, defacto supervisory responsibility over the labour would be delegated to the hospital staff and the birth practitioner. Although the women expected the hospital staff to monitor them throughout labour, they nevertheless felt that unless "something went wrong" they and their support people would retain dominion over the labour itself. The full responsibility for the outcome of birth was seen to shift to the practitioner during the "pushing stage."

The research participants' descriptions of the segmented nature of the birth event corresponds to Brigitte Jordan's (1993:160-164) ethnographic description of the orchestration of 'the birth' by medical and nursing personnel. These descriptions fit the criteria which characterize Davis-Floyd's "technocratic model." In the "wholistic model" (sic),

pregnancy, labour and birth are envisioned as being on a continuum.

The research participants in this study knew that the professional birth attendants would take a governing role during 'the birth;' they had learned that the professional orchestration of the birth event was part of the cultural script. In learning the 'role of the labouring woman' as an aspect of the cultural script, they learned that it was permissible for a labouring woman to seek comfort through physical positioning during labour but that it was not permitted during birth. This contrasts markedly with Jordan's description of the birth event among the Maya (Jordan, 1993:33). In the Mayan case, the labouring woman is taught about birth during the birth event itself. She is not only told about how to push her baby out, but is also shown a variety of birth positions and pushing techniques. The birth attendants then leave it to the labouring woman to find the position that is most comfortable for her.

Davis-Floyd (1992:161) noted that the value placed on the woman's comfort is one of the criterion which again distinguishes the "technocratic model" of birth from the "wholistic model" (sic). She argues that under the "wholistic model" (sic) there is a recognition that the woman's comfort is essential to the well-being of the mother and baby, but that under the "technocratic model," the woman's comfort is "pitted against" the moral goal 'safety.' On this issue, the research participants' concepts adhered more closely to the "technocratic model." Although they wanted to be comfortable, 'comfort' was classified as being a self-indulgent desire which could impinge on 'safety.'

Through the opposition of 'comfort' and 'safety' the research participants could distinguish 'good' from 'bad' or 'appropriate' from 'inappropriate.' When this opposition was applied to the birth setting, for example, home birth was seen to increase 'comfort' and decrease 'safety.' In contrast,

hospital birth was seen to decrease 'comfort' and increase 'safety.' Similarly, within the hospital setting itself, 'comfort' was a feature that was paired with 'labour.' The hospital setting was described as being 'home-like' and 'comfortable' for the portion of the birth event classified as 'labour.' When 'birth' was imminent (or when "something went wrong") the setting was described as being transformed into a 'hospital room.' Curtains which had previously concealed 'equipment' were pulled back, and the bed was to be manipulated and transformed to facilitate 'delivery.'

Finally, the research participants' descriptions suggested that the hospital setting fulfilled more than the moral goal 'safety,' it also fulfilled the moral goal of 'purification.' Analysis of the data indicated that many of the women considered the animal births they had witnessed and the births they had seen in film and on television to be "messy" or "gross." The idea that body fluids are "gross" or "messy" finds a parallel in Horace Miner's (1956) description of body ritual in American culture. He states, "excretory functions are ritualized, routinized, and relegated to secrecy. Natural reproductive functions are similarly distorted" (Miner, 1956:23). This evidence suggested that in this culture, like in many of the cultures described by Mead and Newton (1967:174), birth is considered to be "dirty or defiling." Interestingly, Mead and Newton did not include American birth among those they described as holding this concept. In contrast, Davis-Floyd (1992:125-127) notes that many of the routine obstetrical practices (enemas, perineal shaves, sterile sheets, disinfectant, hand-strapping, baby eye treatments, etc.) are all done for the ritual purpose of purification.

As Davis-Floyd (1992:126) points out, the hospital is not a particularly "clean" environment, if by "clean" we mean a place that is devoid of contagion and body fluids. If anything, the opposite is true, and this characteristic of the

hospital setting impinges on society's moral goal to achieve 'safety.' Nevertheless, the research participants fairly consistently described the hospital setting as a place that was "clean," "sanitary" and "sterile," suggesting that on the symbolic level as well as the literal level they considered the hospital setting to be "clean." This clean place is where women go to do the "messy" and "gross" work of birth. As described by both Miner (1956) and Davis-Floyd (1992:85, 126, 137), rites of purification are carried out within the walls of the hospital "temple" (Miner, 1956:22) and both the mother and the baby are ritually purified. The hospital setting therefore may have advantages beyond 'safety' (the advantage explicitly articulated by the research participants). The hospital may have the added advantage that a woman need not be concerned about contaminating her home with the "messiness" of birth.

Childbirth in Relation to Technology

Although the state of pregnancy and the process of childbirth are categorized as being normal, healthy and natural, neither the research participants themselves, the people in their communities, nor their practitioners took it for granted that their pregnancies were normal or that their labours would be normal. Rather, proof of normalcy was sought through repeated measurements of bodily fluids and dimensions. These measurements during pregnancy served (and would serve during labour), to reassure the research participants that "nothing was wrong." Whether these measurements were derived from amniocentesis, ultrasound, blood tests, urine tests, vaginal exams, or fetal monitoring devices, the tests themselves were viewed by the research participants as being innocuous (except in a few rare instances), and the data derived from such tests were classified as being helpful, reassuring and important.

From their descriptions of the exchanges that took place during appointments with their physicians, the research participants appeared to be more likely to raise the issue of potential abnormality than were their physicians. This included asking the physician to perform an ultrasound or amniocentesis, expressing fears about Down's Syndrome, expressing dismay over weight gain, and seeking confirmation of the benefits of prenatal vitamins. One thirty-four year old research participant classified herself as a borderline high-risk case (due to her age) and consequently sought out a physician who specialized in high risk pregnancy. Particularly for those research participants in late pregnancy, the repeated provision of reassurance of the "normalcy" of their pregnancies increased their expectations of having a normal, healthy, natural birth. Similarly, the unruffled demeanour of their physicians toward the symptoms they experienced during pregnancy served to confirm expectations that their physicians would only intervene during birth if it were necessary.

The performance of diagnostic tests was deemed to be important not only because they were perceived to detect whether something had "gone wrong," but also because if an abnormality were detected, the practitioner was expected to fix it. Even though the research participants did not anticipate that they would need to be fixed (that is they perceived their own pregnancies to be normal, natural and healthy and they expected their labours to follow this pattern), they nevertheless relied on their practitioners to intervene in the unlikely event that "something went wrong." Practitioners were expected to fix the pregnancy of a woman who was "overdue" by inducing labour; they were expected to fix the labour of a woman who was not "dilating fast enough" by augmenting labour; they were expected to fix the birthing woman's perineum by performing an episiotomy if she was "going to tear anyway;" they were expected to fix gross abnormalities of labour (including a reduction in the fetal heart rate and

instances of cephalopelvic disproportion) by performing a caesarean section; and they were expected to fix a woman's inability to continue to "cope" with labour by providing pain medication. The women's statements suggested that the primary role of the birth practitioner was first to detect abnormality, and second to intervene to set the pregnancy and/or birth process back into its normal boundaries, to alleviate prolonged suffering, or to save the life of the mother and/or baby. A third set of 'self-evident truths' derived from the research participants' classification of the appropriate use of technology in childbirth are as follows:

> **The use of diagnostic technology is appropriate because it enables the practitioner to reassure the woman that her pregnancy/labour is progressing along the normal, healthy, natural course.**
>
> **Interventive technology is used when necessary to reinstate a pregnancy/labour that has gone awry (as is the case with induction and augmentation), it is used to prevent potential pathological outcome (as is the case with episiotomy), it is used to help the woman cope with labour (as is the case with pain medication), and/or it is used to save the life of the mother or baby if something "goes wrong" (as is the case with caesarean section).**

There was a fundamental disagreement among the research participants over the last of these self-evident truths, but that disagreement did not centre on the principle of whether or not interventions were necessary. All of the research participants could envision instances in which such interventions were absolutely required. The disagreement therefore revolved around not whether the interventions were helpful or useful, but the extent to which they were deemed to be helpful or useful. Those research participants who had read defensive model material were more likely to suggest that interventions were used indiscriminately, a situation which contradicted their perception of childbirth as normal, natural and healthy. Those research participants who had not read defensive model material (but who had nevertheless been "warned" about the

indiscriminate use of technology) were more likely to suggest that interventions were used only when necessary. The corollary of this is that if an intervention is performed it must be necessary.

At this point I must address the argument made by Lazarus (1994) in her study of women's choice and control in pregnancy and childbirth. Lazarus suggested that much of women's behaviour in relation to pregnancy and birth can be explained by the nature of the asymmetrical distribution of power in the physician-patient relationship. This point is supported by the data gathered in my study; the value of the physician to the research participants was precisely because of the asymmetrical relationship between them. Unlike the research participants, their physicians held specialized knowledge, specialized skills, and the ultimate power to save the woman or her baby. As the women perceived it, the physicians' power derived from technical knowledge and skills, and carried with it the responsibility to intervene when necessary. Because physicians were thought to use interventions judiciously, and because the women knew that interventions were regularly performed, this provided confirmation that the performance of interventions must uphold the moral goal of 'safety.'

In her article, Lazarus further argued that women "'buy' the myths of technology understandably confusing medical facts with medical ideology created and believed by the medical profession" (Lazarus, 1994:29). This raises the question of whether the research participants' perception can be taken as evidence to support Lazarus' argument that women 'buy the myths' created by the medical profession. The answer to this question must be sought through clarification and description of "the myths" women hold and further through comparison of women's myths to physicians' myths.

Taking induction as an example, the willingness of women to either request an induction or accept an induction was based on sound reasoning given the research participants'

perceptions of the consequences of this act. As the women perceived it, the longer the pregnancy was maintained past the "due date," the bigger the baby grew, the less 'room' a woman would have, and the more difficult the birth would be. Also notice that the women perceived that interventions such as episiotomy and caesarean section were performed because of lack of "room." The possibility of giving birth to a bigger baby could therefore be the cause of undesired interventions. Furthermore, the women classified labour on a temporal dimension according to degree of difficulty: "short" labours were classified as "easy" and "very long" labours (twenty-four hours or more) were classified as "horror stories." In the women's perception, the major effect of an induction would be to create a labour that was "fast and furious" [*Becky, 26 weeks*] (page 14); that is, labour would hurt more but would be over sooner than would a non-induced labour. All of the women would have preferred to have "easy" labours instead of "horror stories", and thus an induced labour held some appeal. Given this classification scheme, the request for an induction (perceived to be an innocuous procedure) appears to be a reasonable action.

In contrast to what the research participants knew about induction, an article in the *Journal of Society of Obstetricians and Gynaecologists of Canada* suggests that what is known about inductions within the medical profession contradicts the women's knowledge of induction as a method to "speed up" labour:

> "Few things are more demoralizing for a pregnant patient and her attendants than a prolonged labour, culminating in a caesarean section. As this happens in over 30% of patients who are induced when the cervix is unfavourable, the problem is a clinical condition worthy of serious attention" (Hunter, 1990 reprinted in Milne, 1991:61).

Furthermore, the research participants' categorization of induction as a relatively innocuous procedure (most of them did not consider that there were risks entailed by induction)

is again contradicted by the knowledge held within the medical profession. In another article printed in the *Journal of Society of Obstetricians and Gynaecologists of Canada*, guidelines which define standards of practice for the use of induction are outlined: "Induction of labour is recognized as having definite associated risks for both mother and fetus," and should be performed "when maintenance of the well-being of the baby or mother makes delivery advisable or necessary" (Maternal Fetal Medicine Committee of the *SOGC*, 1989, reprinted in Milne, 1991:59) There is nothing in these guidelines to suggest that inductions should be performed for the purposes cited by the research participants (i.e. excessive fetal growth in the period beyond the due date, or the prospect of faster labour). Rather, the medical indications for induction of labour outlined in the article include seven medical conditions (diabetes, hypertension, etc) and: "Post-maturity: in *selected* cases when the gestation *exceeds* 42 weeks" [italics mine] (Maternal Fetal Medicine Committee of the SOGC, 1989, reprinted in Milne, 1991:59).

Such publications are used by the medical profession as educational tools in an effort to curb the "supply side" of interventive practice in the way that prenatal education is used to curb the "demand side," even though it is recognized that this form of subtle pressure rarely produces the desired effect on medical practice (Milne, 1991:26). Nevertheless, the fact that articles such as these are published can be taken as evidence that there is concern within the medical profession that too many unnecessary inductions are being performed. This suggests that clinicians and their clientele are together deciding what is "appropriate practice" in individual cases without regard to suggested practices set out in medical journals.

The data gathered in this study demonstrate that women both request inductions and willingly accept their physicians' suggestions for inductions. Furthermore, women's knowledge of

induction as an appropriate practice may incorporate "medical myths," but it is equally built around women's ideas about the experience of labour and birth. Women have created their own "mythologies" which differ from the "mythologies" created by the medical profession. This suggests that the acceptance of induction as an appropriate practice could be interpreted equally that women "buy medical myths" and that physicians "buy women's myths."

Regardless of who "buys" whose "myths," together practitioners and women appear to have created a situation which allows neither very much room for movement and restricts their treatment choices. As was stated in the findings chapter, the research participants looked very unfavourably on errors of omission. In light of this, physicians cite their fear of litigation (due to errors of omission) as a major reason for the numerical increase in the performance both of interventions and diagnostic tests even though such interventions and tests are recognized to be of little value (Milne, 1991:21-22). Perhaps both physicians and consumers have higher expectations of the efficacy of technology than is warranted. If this is the case, the tendency to define (unnecessary) interventions as appropriate practice is likely to persist.

At this point it is fitting to address the issue of high technology as a feature of the culture in which we live. The technological environment surrounds both physicians and consumers. The individual's general knowledge of "technology" is reflected in their childbirth knowledge and is part of the world-view of people in this culture. Contact with, and use of devices from automobiles to computer terminals, household appliances, telephones, high-rise buildings, etc., is part of our day to day experience and is essential to our life-way. At some level, people of this culture may be aware of the production of scientific research which demonstrates that each of these technological devices can have harmful effects on the "natural" environment (through both their manufacture and

use), but on another level people may perceive that these technological devices have had liberating effects on our way of life.

The point of this diversion is to suggest that members of this society live in a technologically rich environment, and the environment shapes what we know about ourselves in relation to technology. The consideration of what women know about childbirth and technological devices used in childbirth can therefore not be divorced from their knowledge of technology as an aspect of the environment in which they live. If women (and/or their physicians) hold unrealistic expectations about the efficacy of childbirth technologies, those expectations are derived in part from their ideas about the efficacy of technology in general. When one adds to this the cultural mystique that surrounds scientific medicine, it is not remarkable that women trust in and accept technological intervention.

Childbirth in Relation to Pain

When asked at the outset of each interview to describe what it is like to give birth, the research participants' succinct answers ranged from "some pain" to "excruciating." This indicated to me that the women viewed pain and childbirth as being almost synonymous. Indeed, in Webster's Dictionary (Merriam, 1980:817), childbirth is given as one of the definitions of pain. Webster's defines the concept "pain" as: "1) *punishment*; 2) *usually localized physical suffering associated with bodily disorder (as a disease or injury)*; 3) *pl. the throes of childbirth*; 4) *pl. trouble, care, or effort taken for the accomplishment of something.*" In some respects, all of these definitions were encompassed in the research participants' concepts of the pain women experience during labour and birth.

Beginning with the first definition, there was nothing in the data to suggest that the research participants regarded

the pain of childbirth as being a punishment. This idea existed archaically in Western cultures, however, and became contentious in the childbirth debate of the early twentieth century. At that time, the pain of childbirth was viewed as being woman's punishment for Eve's original sin (Beinart, 1990; Dick-Read, 1953:56; Sandelowski, 1984:6). When turn-of-the-century feminist groups lobbied for access to analgesics to ease the pain of labour they were confronted by morally outraged physicians who argued against the use of pain medication in childbirth; to alleviate women's suffering was seen as lifting the natural punishment imposed by God.

As Sandelowski (1984) described it, the feminist argument was built around the issue of gender equality; men did not suffer pain in childbirth, and women, it was argued, should not be forced to suffer when the technology available could alleviate their pain. Round one of the early childbirth debate was "won" by the women; they gained access to pain medication, and very quickly the administration of pain medication became all but obligatory.

Although pain in childbirth was not viewed by the research participants as being a punishment, they nevertheless repeated the argument put forward by the early feminists: in the modern world a woman should not have to suffer pain if she chooses not to do so. This choice however, would be weighed against the potential disadvantages. Notice, however, that the research participants' acceptance of the use of pain medication in childbirth reverses the opposing values of 'comfort' and 'safety' previously discussed. In the case of pain medication, the research participants recognized the worthiness of increasing a woman's comfort even though they knew that pain medication was not risk-free.

The problem with pain medications has always been that they carried with them increased risks to both the mother and baby and therefore impinged on the moral goal to achieve 'safety.' According to Dick-Read (1953) (who of course had

never experienced childbirth himself), normal childbirth does not and should not entail pain. He theorized that women's experience of pain during childbirth was a culturally conditioned phenomenon and was rooted in the biblical references to pain as punishment. That is, women experienced pain because they expected to experience pain; this expectation was presumed to generate fear, and fear was presumed to physiologically exacerbate pain. Both Dick-Read and Fernand Lamaze (1970), the originators in the West of what was to become the natural childbirth movement, sought to solve the problem of pain in childbirth through changing women's concepts of pain and responses to pain. Part of this reprogramming involved relabelling the physical sensations a woman experiences; rather than experiencing pain women were (and are) taught to apply the word "contractions" to their sensory experience of labour. Cultural concepts, however are not that easy to change. The research participants still defined childbirth as pain. "What, in particular is painful about it?" I asked. The answer: "Contractions."

In a recent phenomenological study among six nulliparous Edmonton women, Vangie Bergum (1989:64-74) eloquently deconstructed the concept pain. She described an incident in which one of the women from her own prenatal classes reproached her: "Why didn't you tell me about the pain?" Bergum's reaction was, "I thought I had" (p. 64). Indeed, the findings of my study suggest that almost everyone who talks about childbirth (the transmitters), talks about it being painful. But, the research participants did not want to "hear" these "horror stories." They wanted to view childbirth as a positive experience and found that accounts of the pain interfered with their concept. There is nothing about pain in childbirth, however, that is inherently negative, rather 'pain' is ascribed negative qualities in this culture.

The concept pain in the second definition above is defined by the sensations one feels as a result of disease or

injury and, like punishment, may be said to carry negative meaning. Furthermore at least in part, the very concept pain carries pathological overtones and therefore on the symbolic level links the category 'childbirth' (a synonym of pain) to the categories 'pathology' and 'medicine.' Yet, as David Morris points out in The Culture of Pain (1991), the cultural tendency to see even pathological pain in purely negative terms is questionable. He argues:

> The medical literature describing the rare cases of people born unable to feel pain suggests that painlessness is not a gift but a curse. These pain-free children tend to die early. We constantly employ the sensation of pain, even at very mild levels, to adjust our posture or shift position, and without such continual minor adjustments we would suffer from inflammations and infections developed when our bones grind down their protective connecting tissue...At times it is easy to wish the affliction had no claims on us, but probably we should train ourselves to think the peculiar thought that the real gift is not painlessness but pain (p. 14).

In Morris' judgment, pain is a requirement of health, not its antithesis. In this culture, however, pain is not always classified as pathological or negative. The final definition of pain above can be said to have positive connotations and is concerned with accomplishment (as in when one takes pains to accomplish something). This pain is not associated with physical sensation except through the metaphorical connection that accomplishment is like pain. Indeed, there are instances in this culture where absolute physical pain (incurred whilst striving to achieve such honours as an olympic medal), is revered, not disdained. People who undergo this voluntary, recreational pain are admired for their accomplishments.
Even though there are (at least) two available cultural metaphors for the experience of pain, however, the research participants fairly consistently focused on the metaphor that connected birthing pain to pathology, while at the same time seeing pain as a normal feature of childbirth.

That women experience pain in childbirth was a 'self-evident truth.' Pain was central to the research participants'

concept of childbirth, it was the "looming, monumental issue" [*Diane, 8 weeks*] (page 1). In the women's concept of childbirth, pain was like the hub of a wheel and most of the other categories of childbirth emanated from it and were seen in relation to it. The 'self-evident truths' which defined the concept of pain were therefore much more complex than has been the case with the 'self-evident truths' examined thus far. As noted below, the women's concept of pain included many strategies for "coping" with pain and for limiting the amount of time during which pain would be experienced:

Experiencing pain is a normal part of childbirth.

It is good to reduce the amount of pain experienced in labour.
- **a) Fearfulness exacerbates pain.**
- **b) Education (childbirth knowledge) reduces fear and thereby reduces pain.**

A woman can learn how to cope with (reduce) the pain of labour by enroling in prenatal education classes.
- **a) She learns breathing and relaxation techniques.**
- **b) She learns the pain reducing potential of anaesthesia and analgesia.**

It is better to cope with labour by using breathing and relaxation techniques than by using drugs.

The longer labour goes on, the more pain the woman will experience.
- **a) It is worse to experience pain over long periods of time.**
- **b) It is better to experience a short labour than a long labour.**
- **c) If labour goes on too long, it is good to use drugs to speed it up.**

It is good to get labour over as quickly as possible.

Coping with labour requires strength (both physical and mental)
- **a) having support increases psychological and emotional strength**
- **b) prenatal exercise increases physical strength**

When a woman has no more strength, drugs are needed to help her "get through."

Although the research participants remained open to the possibility that they might require pain medication during labour, almost all of them intended to use breathing and relaxation techniques and "support" as their first strategy for coping with labour. According to the women's statements, a labouring woman requires the emotional support provided by her husband or partner, or in one case, her mother, to help her cope. Some of the women intended to bring additional support people into the birth chamber such as a midwife or labour support person, a massage therapist, a person to perform therapeutic touch, and a friend. In addition to this primary support, the labour and delivery nurses were expected to provide secondary support if and when it became necessary. This emotional support was seen to strengthen the woman's capacity to cope with labour. Going through labour was viewed as something a woman cannot, or at least should not have to do on her own, as had been the case in the research participants' mothers' time.

There was no indication in the research participants' statements that either the woman herself or her support person would inherently know how to cope with labour. Rather, a method for coping with labour was something they both must learn in prenatal education classes. After having learned these techniques, the support person was to be given the responsibility (under the supervision of the nursing staff) for keeping the labouring woman "on track" by making sure she continued to breathe and relax "properly." The nursing staff were also expected to supervise the labouring woman, to judge how she was "handling it," to suggest techniques which would help her to improve her performance or to offer drugs if she was not "handling it" well. This suggests that although the women emphasized that they would control the decision to take pain medication (i.e. they perceived themselves as acting autonomously), their criteria for making that decision would

be based, in part, on the nurses' evaluation of their performance.

Childbirth in Relation to Autonomy

For several decades advocates on either side of the childbirth debate have contended for the prerogative to define appropriate childbirth practice. Both sides, however, have long recognized that through her behaviour the consumer wields the power to define appropriate practice; she can contribute to the definition by demanding specific childbirth services or she can contribute to the definition by refusing consent to specific childbirth services. Both sides further recognize that the consumer's tendency to demand or refuse childbirth services will be influenced by what she knows about childbirth. Both sides use childbirth education (whether through, books, films, prenatal education programs or peer pressure) as a strategy for informing women of their respective definitions of appropriate childbirth practice. Both models of childbirth education assume that if women have the right information they will behave appropriately (in compliance model terms) or make the right choices (in defensive model terms). The corollary of this is that if women behave inappropriately or make the wrong choices they must have the wrong information. The idea that women can have the right information and either behave inappropriately or make the wrong choices is inconceivable.

The premise underlying the defensive model platform is the idea that ultimately the consumer can withhold her consent to any medical procedure. Refusing consent, however, is seen to be both stressful and difficult during labour and therefore the consumer is advised to circumvent such potential confrontation by selecting a practitioner with low intervention rates. She is further advised to avoid signing a blanket consent form upon arrival at the hospital. If an intervention is suggested, she is advised to evaluate the merits of each procedure and to withhold her consent when she considers a

procedure to be unnecessary or not beneficial (Korte and Scaer, 1984:95: Boston Women's Health Collective, 1984:584).

If a woman refuses her consent, this can of course be overturned by court order, but court orders are very seldom necessary to enforce the practitioner's right of access particularly among middle class women who adhere to the values of the dominant (North American) culture (Irwin & Jordan, 1987). Herein lies the major flaw in the defensive model argument, and this flaw did not go unnoticed by the research participants. The research participants did not, and could not envision challenging their physicians' medical knowledge. Rather, the data is permeated by statements which indicated that the women "trusted" their practitioners' "judgement" and based on this trust they intended to follow their practitioners "recommendations." The practitioner's right of access therefore, is virtually guaranteed in a culture which values the practitioner's (authoritative) knowledge above the woman's knowledge. Practitioners are trained and skilled people who know what to do, and women ostensibly hire practitioners to gain access to their specialized knowledge and skills. If a woman withholds her consent, she makes the tacit statement that she values her own knowledge above that of the practitioner, and if a woman inherently knew what to do anyway, she would not have required the services of a practitioner in the first place. This may be stated in the form of a fifth 'self-evident truth':

> **When a pregnant woman engages a practitioner, her autonomy in relation to that practitioner, is limited by her lack of specialized knowledge and skills.**

The autonomy a woman holds over her body, although legally defined, is more theoretical than concrete. As the research participants perceived it, the childbirth knowledge they held gave them very little leverage to challenge their practitioners. For example, when Jackie implemented her prenatal teacher's instruction "You're the consumer, make your

requests known," [*Jackie, 35 weeks*] (page 19) she found herself in the position of having to choose between conflicting sets of information. The teacher had warned her about physicians' tendencies to intervene, but her physician denied the prenatal instructor's accusation telling Jackie that (Canadian) physicians do not intervene unnecessarily. Similarly, when the other research participants questioned their physicians about the practice of episiotomy, they felt they had little recourse whether or not had they received an acceptable answer. Some of the research participants did change practitioners, but only in one case (from physician to midwife) was this due to having received the "wrong answer." The other research participants changed practitioners because they had been unable to develop a 'good' relationship with their practitioner. These participants often received the same "wrong answers" from the both the first and second practitioners, but "wrong answers" were considered to be of secondary importance to the relationship.

In some respects the compliance model material was more insidious than that of defensive model. Whereas all of the research participants could recognize the political platform on which the defensive model was built, to most research participants the compliance model platform was invisible. Like the defensive model, compliance model material is clothed in the language of consumerism, autonomy, and the values of education. Unlike defensive model material, which tends to maximize the risks of intervention, compliance model material minimizes or ignores the risks of most interventions (also see Sargent & Stark, 1989 on this issue). As was apparent from the data, compliance model educators often presented both the risks and the benefits of only one intervention (pain medication). In addressing the risks of only pain medication, however, the compliance model material implied that the risks entailed by other interventions would have been outlined in like manner. The absence of information was therefore inter-

preted to mean there was an absence of risk. If women believe they have been presented with all the facts when they have not (as was the case with the research participants), the compliance model material does women a disservice.

To state it another way, the compliance model material does not address the "demand" side of the intervention problem. For example, Donna expressed that "My biggest fear actually is having to have a c-section, I'm just really terrified of that" [*Donna, 34 weeks*] (page 2). Donna nevertheless intended to request an induction shortly after her expected due date had passed. Neither her compliance model reading material, nor her compliance model prenatal teacher had presented her with the information that an induction could increase her risk of caesarean section. Since induction was one of the interventions over which the research participants felt they had control, the dissemination of comprehensive information might have some effect on the "demand." In contrast to many of the women who had only been exposed to compliance model material, none of the women who were aware of the risks of induction (via defensive model material) indicated that they would request an induction, although they would have considered induction if it were recommended for appropriate (medical) reasons.

Although compliance model material does little to curb the "demand" for interventions such as induction, compliance model educators implicitly recognize the woman's difficulty in maintaining autonomy over the decision making process at the time an intervention is recommended. Nevertheless, this recognition cannot excuse the failure to provide accurate information about both the risks and the benefits of the range of commonly used interventions. The research participants preferred it when they were given the "truth;" they neither wanted to be mollified, nor cajoled into taking "sides" in the childbirth debate. In this respect, the persual of political agendas by educators in both models failed to serve the

research participants needs. Of course, any of the women could have conducted further research on any of the controversial issues to determine which version of the "truth" fit with their own concepts and expectations. Remarkably however, only one of the women suggested that she intended to conduct this kind of research in the medical literature (in this case to determine which of the two views of episiotomy was correct).

Much of the prenatal educational material is of course derived from medical research, and childbirth is described and defined within the framework of medical ideology. As Arney (1982:20-50) argued in his examination of the history of the profession of obstetrics, once members of society began to accept medical definitions of childbirth (beginning in the seventeenth century), the childbirth debate could only be waged within the framework of medical categories. Therefore, prenatal education itself, whether of the defensive or compliance model persuasion, reinforces the principle that medical knowledge is more valuable than women's knowledge and further implies that women require medical knowledge in order to give birth. The consequence of this is that women are more likely to define themselves in medical terms, and thereby become more vulnerable to interventions (see Tanzer, 1972, for an early comparative study of births experienced by prenatally educated and uneducated women).

The concept of childbirth as a medical phenomenon may have problematic consequences, but it appears to be an irreversible fact. The problem with the opposing models of childbirth education is therefore not so much that they construct childbirth in medical terms, but that they selectively cite the medical literature which upholds their respective political ideologies. The two forms of prenatal education therefore failed to address both aspects of the research participants' integrated concept of childbirth. Under these conditions, women can scarcely be expected to act autonomously unless the material presented enables them to

evaluate the merits of conflicting evidence and make reasoned decisions from that evidence.

As a final note to this section on autonomy, there were data to indicate that two of the research participants made autonomous decisions about circumcision. Emily, who was willing to "go along with" (page 18) her physician's advice with regard to (undesired) interventions and birth position was unwilling to accept her physician's advice with regard to circumcision. Although her physician attempted to dissuade her from performing a circumcision (in the event she gave birth to a male child), Emily took the initiative to research the issue. She acquired literature and sought advice from her parents, her in-laws, her co-workers and her friends, and subsequently made the decision to hire a different physician to perform the operation. Similarly, Janice researched the issue with the aid of both her obstetrician and her sister, and subsequently made the decision that circumcision was an unnecessary surgical operation. In both cases, the physicians used their persuasive powers, but ultimately the choice regarding circumcision rested with the women. There was little evidence in the data however, to indicate that a similar style of openness existed whereby the risks and benefits of obstetrical procedures were weighed.

Discordance Between the Research Participants' Concepts of Birth and the Reality of Childbirth Practice in Alberta

When the women envisioned their forthcoming births, they imagined them as being "normal" and "natural," and at times they used the terms "normal" and "natural" interchangeably. Both terms carried meanings which differentiated "normal" or "natural" birth from those in which complications or (some) interventions featured. Although it was difficult to determine exactly what was meant by the terms "normal" or "natural" childbirth, eight of the research participants excluded all interventions in their definition of "normal" or "natural."

At the other end of the spectrum, two women categorized birth via the vaginal canal as the only requirement of "natural" or "normal," regardless of other interventions. The dividing line placed between caesarean section (not-normal/not-natural) and vaginal birth (normal/natural) was consistent across all research participants. Five women further defined "natural birth" as one in which no pain medication was used. In contrast, two women stated that one could have both pain medication and a natural birth. Six women described a perineal tear as being natural, and three women opposed the terms "episiotomy" and "natural." Only three of these women could be said to have subsumed episiotomy under the "no intervention" category, therefore for them, having an episiotomy appeared to exclude the possibility of having natural birth. For the other six women it was unclear whether one could have both an episiotomy and a natural birth. A further five women excluded induction from their definition of "normal" or "natural" and in two cases this was subsumed under the "no intervention" category. A host of other features of childbirth were identified as being "natural" including birth with a midwife in attendance, the home setting, the home-like hospital setting, the holistic approach to birth as opposed to the medical approach, an upright birth position, water birth, breast feeding, and alternatives to medical and surgical induction such as nipple stimulation. The two additional features of childbirth which were identified as being "normal," included the hospital setting and a birth in which there were no complications.

From this data it is impossible to define the exact dividing line between "normal" or "natural" birth and "non-normal" or "non-natural" birth. The research participants' categories existed on a continuum, but in general interventions and complications tended to move a birth from the "natural" or "normal" category to the "not natural" or "not normal" category. Similarly, although the hospital setting

was defined as "normal" it only became "natural" when decorated to appear like the home setting. Finally, such things as a "natural" tear were seen to be less desirable than the "clean cut" of an episiotomy, although both tearing and an episiotomy were considered to be undesirable.

In her study, Lazarus (1994) remarked that her interviewees had spoken "about childbirth as a natural process, [but] to differing degrees they accept and often prefer a medicalized birth" (p. 25). Although this statement was consistent with the data gathered in my research, I cannot agree with Lazarus' conclusion. The women in my study did not appear to define the terms "medicalized birth" and "natural birth" as mutually exclusive categories. Rather childbirth appeared to be conceptualized as both medical and natural simultaneously. That is, the research participants preferred a 'medicalized natural birth' and did not think that having a medicalized birth excluded the possibility of having a natural birth and vice versa.

Instead, birth was inherently medicalized through the language the research participants used to describe birth (contractions, cervix, dilation, pelvis, vaginal canal, fetus, etc.); it was medicalized through their expectation and acceptance of monitoring and diagnostic tests (including ultra sound, amniocentesis, blood tests, urine tests, weight measurements, fetal monitoring machines, vaginal exams, etc); it was medicalized through their preference of the hospital as the "proper" or "normal" birth setting; it was medicalized through their preference of physicians and nurses as the "proper" birth attendants. Within this framework, the women expected to have a "natural" birth; they "hoped" to avoid medical interventions (while recognizing that medical interventions were necessary in certain cases).

The research participants' concepts of childbirth also appear to be consistent with the evidence cited by Beaton and Gupton (1990) in their study of women's expectations of

childbirth. These researchers, however, did not conclude as I have, that women hold an integrated concept of 'medicalized natural' childbirth. Rather, they suggested that women's expectations were romanticized and unrealistic, and they recommended that childbirth educators accept the challenge to "prepare women for the realities of childbirth without destroying the excitement" (Beaton & Gupton, 1970:138).

Whether or not one considers the research participants' expectations and concepts of childbirth to be unrealistic, there is evidence to demonstrate that their expectations were not consistent with actual childbirth practice in Alberta. Although it was impossible during this research study to locate comprehensive material which adequately describes the extent to which interventions are used in local childbirth practice, I was nevertheless able to compare two sets of statistical records in order to derive an approximate and partial description of rates of diagnoses and intervention. These statistical reports were compiled by separate agencies, each of which differentially defines its reporting periods and each of which focuses on a particular aspect of childbirth practice. Fortunately the criteria used to define categories remained consistent across agencies.

One of the statistical reports I examined is a publication of the Alberta Medical Association (A.M.A.) (1994). The A.M.A. collects statistics for the purpose of reviewing the medical profession's overall performance in relation to the rates of mortality and morbidity during childbirth. They also reported the rates of two interventions (caesarean section and induction), and they were the only agency to report the number of pregnancies that occur per year. Their reporting period coincides with the calendar year.

The second statistical report I examined is a publication of Alberta Health (1993), the policy making arm of the provincial government's Department of Health. Alberta Health collects statistics for the purpose of discovering the causes

of hospitalization and the number of days patients are hospitalized according to diagnoses and procedures. Their reporting period begins April 1 and ends March 31. Alberta Health was the only agency to report the number of obstetric diagnoses and the number of obstetric procedures performed per year. Alberta Health defines the categories of diagnoses and procedures in accordance with the Canadian Diagnostic Codes (Statistics Canada, 1986) and the International Classification of Diseases [ICD·9·CM] (Practice Management Information Corporation, 1992). Both these documents were consulted to obtain the criteria used to define each reported category. Although both Codes separate and define numerous obstetric diagnoses and procedures, Alberta Health does not report the incidence of each discrete procedure or diagnosis, but rather groups several categories together in its reporting. Induction, episiotomy and augmentation of labour are thus grouped, the use of forceps, vacuum extraction and breech delivery are grouped, caesarean section is categorized alone, and the administration of pain medication is unreported. The diagnoses of conditions of childbirth include the ungrouped category, "normal delivery," and the grouped categories "other complications related to pregnancy," "indication for care in pregnancy labour and delivery," and "complications occurring mainly in labour and delivery."[1] (see note for the inclusion criteria in each of these categories).

The chart below displays a rough approximation of the reality of childbirth practice in Alberta. All records here discussed pertain to the year of 1991 (at least two years prior to the time of the research participants' expected birth events). Note that it was necessary to derive the rates of diagnoses and interventions by using the number of pregnancies reported by the A.M.A. and the absolute numbers of diagnoses and procedures reported by Alberta Health. Neither Alberta Health nor the Alberta Medical Association were specifically

concerned with the question: To what extent are interventions used in childbirth practice in Alberta?

Although the Alberta Health data can be examined in isolation for evidence of the relative incidence of various diagnoses and procedures, such an examination could lead to misinterpretation of the data. Unfortunately, the Alberta Health statistics are reported both as absolute numbers of diagnoses and procedures and as an expression of the incidence of diagnoses and procedures per 100,000 population; there is no indication of the absolute number of women who were hospitalized for 'childbirth' during the reporting period. Indeed, the number of obstetric diagnoses reported by Alberta Health exceeds the number of pregnancies reported by the A.M.A. by seventeen thousand, and the reported number of procedures exceeds the number of pregnancies by three thousand. Any one woman can be diagnosed with several conditions (for example, both hypertension and perineal laceration) and can be the recipient of several procedures (for example, both an induction and a caesarean section). Furthermore, although the A.M.A. reports the number of pregnancies, their criteria for defining of 'pregnancy' is "all pregnancies delivered after 20 weeks gestation or with a fetus weighing > or = 500 g." (A.M.A., 1994:64). This would suggest that spontaneous abortions (miscarriage) occur prior to twenty weeks and are not counted as 'pregnancies.'

Notice also that there is a three-month discrepancy in the reporting periods of the two agencies, however this should have little impact on my derived figures as the number of pregnancies has remained fairly constant for several years. Finally, the rate of caesarean section was reported by the A.M.A. to be 16% (A.M.A., 1994:64) and is fairly consistent with my derived figure (16.54%). This suggested that the use of one set of figures to derive rates from a second set of figures should give a fairly reliable indication of actual practice.

TABLE V Childbirth Practice in Alberta

	ABSOLUTE NUMBER	APPROXIMATE RATE PERCENTAGE OF ALL PREGNANCIES
Total Number of Births (including twins etc.) 1/1/1991-12/31/1991 (A.M.A., 1994:10)	43,092	
Total Number of Pregnancies 1/1/1991-12/31/1991 (A.M.A. 1994:57)	42,581	
DIAGNOSES: *Complications of Pregnancy, Childbirth and the Puerperium* (Alberta Health, 1993:34)	59,889	
Total Number of *Normal Deliveries* 4/1/1991-3/31/1992 (Alberta Health, 1993:34)	5,947	13.96%
Total Number of *Other Complications Related to Pregnancy* 4/1/1991-3/31/1992 (Alberta Health, 1993:34) (note some of these diagnoses apply to childbirth and some only to pregnancy)	11,593	??
Total Number of *Indication for Care in Pregnancy, Labour & Delivery* 4/1/1991-3/31/1992 (Alberta Health, 1993:34)	16,045	37.68%
Total Number of *Complications Occurring in Labour & Delivery* 4/1/1991-3/31/1992 (Alberta Health, 1993:34)	17,547	41.20%
Total Number of *Spontaneous Abortion; Legally Induced Abortion; Other Abortion; Other Pregnancy with Abortive Outcome;* 4/1/1991-3/31/1992 (Alberta Health, 1993:34)	6,225	n.a.
Total Number of *Haemorrhage of Pregnancy* 4/1/1991-3/31/1992 (Alberta Health, 1993:34)	2,368	n.a.
Total Number of *Complications of the Puerperium* 4/1/1991-3/31/1992 (Alberta Health, 1993:34)	569	n.a.
PROCEDURES: *Obstetric Procedures*	45,724	
Total Number of *Forceps, Vacuum and Breech Delivery* 4/1/1991-3/31/1992 (Alberta Health, 1993:108)	5,606	13.18%
Total Number of *Other Procedures Inducing or Assisting Delivery* 4/1/1991-3/31/1992 (Alberta Health, 1993:108)	17,589	41.30%
Total Number of *Caesarean Section and Removal of Fetus* 4/1/1991-3/31/1992 (Alberta Health, 1993:108)	7,044	16.54%
Total Number of *Other Obstetric Operations* 4/1/1991-3/31/1992 (Alberta Health, 1993:108)	15,485	36.36%

Whatever other conclusions can be drawn from these figures, one thing is certain: actual childbirth practice in Alberta does not reflect the research participants' concept of childbirth as a normal, healthy, natural process. Indeed, women in Alberta have a greater probability of undergoing caesarean section than they do of having a "normal delivery." Leaving aside the issue of intervention rates, the comparison of the diagnoses rates of "normal delivery" with that of "indication for care in pregnancy, labour and delivery" and "complications occurring in labour and delivery" indicates

that the vast majority of cases of parturition are categorized and treated as pathological, not as normal, healthy and natural at all.[2]

Given this evidence, the question that arises is: Why did the women view childbirth as a normal, healthy and natural process when the manner of childbirth practice suggests the opposite? I am not suggesting that the research participants knew the figures here presented. Based on the knowledge they had acquired from their peers and elsewhere, however, the women were acquainted with very few women who had actually experienced a normal, healthy, natural birth. In other words, it is difficult to fathom how they could conclude that: childbirth is a normal, healthy, natural process that could "go wrong" at any moment, when almost all the evidence that they had acquired suggested that childbirth is rarely a normal, healthy, natural process and it usually "goes wrong."

A partial explanation for this phenomenon is that the research participants' evaluations of the birth experiences they had encountered was tempered by an applicability factor and by their concept that "everybody's different." Very often the women rationalized the stories they had heard by categorizing the "horror" stories either as being atypical or in some way different from themselves. According to their interpretation, a normal, healthy, natural birth was not newsworthy and this accounted for the over-representation of "horror stories" among the birth stories they had heard.

The idea that normal birth is not newsworthy enough to require comment led the research participants to dismiss the sensationalized "horror stories" they had repeatedly heard. The women had heard the stories, but they did not necessarily find them instructive. They knew birth was not like this. Except in very rare cases, the women listened to only that information which supported the 'self-evident truths' they had learned over time. As Diane stated: "I don't personally know what's true and what's not true. I just kind of go with my

gut feeling" [*Diane, 8 weeks*] (page 17). When faced with a similar plethora of conflicting information which variously challenges and supports the "truth" as we know it, how many of us would do otherwise?

Conclusions

This study was designed to assess the circumstances under which nulliparous women learn about childbirth during the available learning time, limited on one end by the woman's awareness of her pregnancy and on the other by the imminence of birth. The lack of qualitative difference between the knowledge held by the women in the early stage of pregnancy and those in the later stages suggested to me that much of what they knew about childbirth was learned in the period prior to pregnancy. The women entered pregnancy with a set of preconceived ideas about the physical and emotional experience of birth; the birth setting; the role of birth attendants; and the rationale for interventions. The knowledge learned during pregnancy was interpreted within the framework of their preconceived ideas, and although this new knowledge both clarified and reinforced their concepts, it seldom changed those concepts. This is not to suggest that there was no difference among the twenty-four research participants, but it is to suggest that the difference could not be explained by attendance or non-attendance at prenatal classes; nor could it be explained by the stage of the woman's pregnancy (one of the questions addressed in this study).

One of the important variations found in the data, was that women in the later stage of pregnancy tended to attribute their knowledge acquisition to prenatal classes and reading, and therefore placed a higher value on the knowledge acquired from authoritative sources during pregnancy. In contrast, those women who had not yet attended prenatal classes and who usually had read very little about childbirth (although much about pregnancy), tended to attribute their knowledge acquisi-

tion to informal sources. Regardless of the stage of pregnancy, informal sources were not highly valued by most of the research participants, and this form of knowledge acquisition was generally assigned lower credibility than that assigned to knowledge acquired from more authoritative sources. In other words, people in the informal sector did most of the "work," but experts were given most of the "credit."

Despite the low credibility assigned to informal sources, the research participants' descriptions of the circumstances surrounding the acquisition of discrete bits of childbirth knowledge provided ample evidence to support the conclusion that the cultural transmission of childbirth knowledge in the period prior to pregnancy is probably more important in shaping women's concepts of childbirth than was the case in the period after pregnancy. Only two of the women (both of whom had read defensive model material for the first time during pregnancy), described themselves as having reformulated their concepts of childbirth. This conforms to the second patterned variation detected in the data: there was a qualitative difference in the women's knowledge of the risks and the benefits of interventions, and this difference could in most cases be attributed to the distinctiveness of the information contained in defensive model reading material. Women who had been exposed to the defensive model through people, could sometimes define some of the risks of interventions, whereas women who had been exposed to defensive model reading material (whether prior to or post-pregnancy) could almost always define the risks of all four interventions addressed in this study. This suggests that information that did not confirm the women's preconceived concepts, had to be read to be believed. Nevertheless, a certain amount of receptivity on the part of the woman was also required: the material could be read but not believed.

There were data to suggest that the mere exposure to defensive model material, or material pertaining to childbirth

alternatives was not enough to alter the women's plans for birth. Of the two women who described themselves as having altered concepts after reading defensive model material, one of them opted for a midwife attended home birth, and one did not. In contrast to most of the other research participants, neither of these two women had previously been exposed to people who had experienced home birth and midwifery care. Two-thirds of the research participants however, had been exposed to these alternatives through their peers, through their mothers, or in one case, through her physician, and could have, if they wished, gained access to these alternatives. Of the remaining eight women, all but one of them was aware of the local midwifery practice through newspaper and television news reports.

The data suggested that most of the women rejected the alternatives of midwifery and/or home birth not because they lacked knowledge of the philosophical underpinnings of the alternatives, nor because they lacked knowledge of the availability of alternatives, nor because they did not know how to gain access to those alternatives. Rather, they rejected the alternatives because the only real distinction they could make between hospital birth and home birth, was that hospitals, nurses and physicians were thought to provide a safety net and home birth and midwives were not. As the research participants described it, women who give birth in the hospital are like women who give birth at home in that they have freedom of movement and could "pretty well do what they want" (Emily, page 13) until the beginning of the "pushing stage." They further viewed the "normal" hospital setting to be "natural" and home-like. Finally, they expected to have normal, healthy natural births, and did not feel that they needed to be at home in order to do so.

The idea of giving birth at home did not appeal to most of the research participants because although home birth and/or midwives fit their concept of childbirth, it only fit

the half which recognizes childbirth as being normal, healthy and natural. Only by giving birth in the hospital could the women act in accordance with the other half of their concept of childbirth: the half which recognizes childbirth as potentially pathological (A few of the women recognized that if "help" were required, midwives were capable of providing it, although not always in the home setting). As the women described it, the hospital offered the "help" they might require at a moment's notice. To cut themselves off from this "help" seemed to all the women to be foolish (including the woman who planned to have a home birth but intended to use the hospital if necessary).

I have argued in this chapter that the research participants adapted themselves to two seemingly opposing concepts of childbirth, neither believing one nor the other as "truth," but incorporating elements of both in their concept of childbirth. The failure to recognize the existence of this integrated concept perpetuates the childbirth debate. Educators working within the two conflicting models of childbirth education vie for converts among those that they "educate." Neither form of prenatal education therefore addresses the needs of women, but instead they address and pursue their own ends using women as instruments or means to their own ends.

Limitations of Study and Implications for Further Research

When I began this study I was operating under the false, but common assumption that the major portion of learning about childbirth occurs during the period of pregnancy. Fairly early in the data gathering stage however, the research participants' statements (particularly those in early pregnancy) refuted my presuppositions, lifted my conceptual barriers and prompted me to probe more deeply in subsequent interviews for evidence of learning about childbirth prior to pregnancy. My major conclusion that the most formative time

for learning about childbirth is in the pre-pregnancy period, nevertheless requires further substantiation with data gathered from non-pregnant women, teens and children. Such studies could reasonably be expected to confirm the finding that women hold a set of 'self-evident truths,' which not only guides their behaviour during pregnancy, but also limits their ability to hear and interpret information which does not conform to those concepts.

The findings of this study confirm and support many of the findings in Beaton and Gupton's (1990) study of women's expectations of childbirth and the findings in Lazarus' (1994) study of the issues of choice and control in childbirth. Unlike these two studies which focused only on hospital birth, this study incorporated the contrast between the alternatives of home birth/midwives and hospital birth. At the outset of the study it had not been my intention to explore this issue, but it became clear early in the data collection phase that the majority of the research participants thought about childbirth in relation to the available alternatives. The knowledge that there was a choice available may have at some level forced them to come to terms with and articulate their preference for hospital birth. This finding therefore may be an artifact of the particular locale in which the study was conducted, and similar data could probably not be collected in locales where alternatives and knowledge of those alternatives did not exist.

The findings from this study are further limited by the characteristics of the participants in the research. Although their range of ages, income levels, occupations and family and ethnic backgrounds varied, all the research participants were middle class women and all of them identified with the dominant culture. I would therefore not expect these findings to be representative of all Edmonton women. Rather, it is very likely that consistent patterned variations would be found in any study which addressed this issue within a

particular ethnic group, age group, occupational group, and perhaps low or high socio-economic groups.

Two American studies conducted by Lazarus (1994) and Kinnard (1984) among low socio-economic women suggest that this group of women may have different concepts and methods of learning about birth than middle class women. Their findings, however, are difficult to apply to Canadian women due to the differential nature of the health care systems in the two countries.

Although I suspect that the integrated nature of the concept of childbirth is culturally pervasive, I can make no claim to suggest this is indeed the case as my data pertains only to middle class nulliparous women in Edmonton. Further research could be conducted to determine whether this integrated concept exists more generally, and whether it exists differentially among specific groups (particularly those groups involved in childbirth education and practice). Such research would provide added insight into the way childbirth is valued and practised in this society.

Finally, the research participants occasionally emphasized that the authoritative material to which they had access was of non-local origin. This made it difficult to interpret within the local context the information contained in books, films, newspaper and television reports of, for example, the escalating caesarean section rate. Non-local material, therefore was often dismissed and filed away in the "inapplicable" category. The development and dissemination of material that is locally based, and reflects the reality of local practice, would probably be considered a valuable addition to the educational materials already available. Admittedly one such book that is already available (Sinclair, 1989) was selected by only two of the research participants from among a host of library books. Both women nevertheless considered this book to be one of their most valuable resources (Also see

Damsma, 1994:36 for similar findings regarding the value of local material).

In order to be considered "credible" any material developed to reflect local practice would need to be regularly updated to keep it both current and comprehensive (Sinclair's work has many gaps, which is not surprising given the manner in which records of childbirth practice are kept and compiled). The development of statistical reports that reflect local intervention rates would be a massive project, and would probably be best undertaken as part of the reporting practices of Alberta Health. If Alberta Health were to compile statistical data to reflect local practices, those reports could then be used as source documents for the development of prenatal educational material.

To reach the greatest number of women, this educational material would most effectively be distributed through prenatal education classes. In addition, the material would need to be written in a style that was neither condescending nor linguistically baffling. It would need to address the issue of how each practice can potentially effect the woman's experience of childbirth, as well as addressing the purely physiological affects. It would acknowledge both the advantages and disadvantages entailed by common medical procedures and it would incorporate reasoned arguments outlining these advantages and disadvantages. As will be noted from the research participants' decisions about circumcision, this approach to 'education' is effective.

Furthermore to be valuable, this material would need to address both halves of women's integrated concept of childbirth; it would need to be responsive to what they know rather than prescriptive of what prenatal educators think women need to know. In other words it would need to omit the classic prenatal educational agendas which have either attempted to undermine women's trust in their practitioners, or alternately have attempted to condone (through silence) questionable

practices. It would need to demand nothing from women (i.e. that they either comply with the system or challenge the system) in exchange for information, and it would not make false promises of 'easier' birth nor would it threaten women with dire consequences. Above all else, this approach would respect women's intelligence and ability to make the choices that are best for them.

Whether or not the development and dissemination of such locally based material is feasible is another question. If it were to be distributed through prenatal education classes, it would require the suspension of the childbirth debate, and it would require traditional adversaries to respect each others' point of view. In other words, it would require co-operation rather than confrontation; and this suggests nothing more nor less than a transformation of the culture surrounding childbirth education and the cultural transmission of childbirth knowledge.

Such an information package, if used appropriately, would remove the responsibility from prenatal educators to "prepare" women for childbirth, and it would relocate the responsibility to where it already implicitly exists: that is with the women themselves. Such an information package could not be predicated on a policy in which there is a defined purpose to change (reform) current childbirth practice (that is, it could not be used as a tool to attempt to reduce rates of intervention; that was one of the original purposes of prenatal education (Dick-Read, 1953:115-123; Lamaze, 1970:173; Beck, 1979:254), and it has been a miserable failure). Nor could it be predicated on a policy in which the intended purpose is to change women's concepts of childbirth (i.e. devalue women's knowledge and the knowledge of members of their communities in favour of an authoritative version of the "truth"). The only purpose of such an information package would be to broaden women's knowledge of birth practices within the local context by providing a resource whereby pregnant women could effec-

tively prepare themselves "for the realities of the childbirth experience" (Beaton & Gupton, 1990:138).

The consequences that could result from the introduction of such an information package are both unforseen, and unforeseeable (anything introduced into a cultural system has either the potential for far-reaching consequences or complete rejection). Nevertheless, the one potential consequence that could, and hopefully would result from the introduction of such a package, is that it might reduce the amount of bitterness women feel after they give birth and subsequently encounter material which conforms to their experience and challenges their preconceived ideas. A woman who had access to credible, comprehensive, current, and local material (i.e. applicable) could not bitterly claim, as so many women have: "No one ever told me."

Notes to Chapter V

1. Please note that the figures cited do not reflect the number of diagnoses that occurred in Alberta, but the number of diagnoses listed on the charts of patients who were *hospitalized*. Diagnoses related to pregnancy and childbirth rank first, third, fourth and sixteenth among the leading diagnoses in Alberta hospitals (Alberta Health, 1993:65). To state this another way, factors related to pregnancy and childbirth are the leading cause of hospitalization in Alberta.

The description of the medical criteria used to define each of the categories of diagnoses and procedures are listed below. This should not be interpreted as an exhaustive list, rather, the list below is an extrapolation of criteria in order to allow the reader to understand the types of conditions defined under each category. The criteria are as follows:

DIAGNOSES (Practice Management Information Corporation, 1992: 149-153).

Normal delivery is defined as "Delivery in a completely normal case: delivery without abnormality or complication classifiable elsewhere...and with spontaneous cephalic delivery, without mention of fetal manipulation [e.g., rotation, version] or instrumentation [forceps]." This category excludes breech births and caesarean section.

Other Complications Related to Pregnancy includes conditions that arise during pregnancy and that may be present at the time of birth including placenta previa, placenta abruptio, hypertension, pre-eclampsia, eclampsia, premature labour, prolonged pregnancy, venereal diseases, diabetes and several other medical conditions and pathologies. This grouped category also includes many symptoms specific to pregnancy such as vomiting, and bleeding in early pregnancy. The incidence of *Other Complications Related to Pregnancy* was reported to be 11,593 (Alberta Health, 1993:34), however there is no indication of how many of these diagnoses were a feature of "birth" and how many were a feature of "pregnancy."

Indication for care in pregnancy labour and delivery excludes the category "obstructed labour" and includes: several categories of multiple gestation; several categories of malpresentation; several categories of disproportion; several categories of "abnormality of organs and soft tissue of the pelvis" (including previous caesarean scar); several categories of "known or suspected fetal abnormality affecting management of mother" (excluding "fetal distress in labour and

delivery due to drug administration"); several categories of "other fetal and placental problems affecting management of mother;" several categories of "other problems associated with amniotic cavity and membranes;" and several categories of "other indication for care or intervention related to labour and delivery, not elsewhere classified" (including "failed mechanical induction" and "failed medical or unspecified induction").

Complications occurring mainly in the course of labour and delivery includes: several categories of obstructed labour; several categories of "abnormality of forces of labour;" several categories of "long labour;" several categories of umbilical cord complications; several categories of "trauma to perineum and vulva during delivery" (including "damage from instruments; that from extension of episiotomy;" first degree laceration; second degree laceration following episiotomy; third degree laceration following episiotomy, fourth degree laceration); several categories of "other obstetrical trauma" (including rupture of the uterus); several categories of postpartum haemorrhage; several categories of retained placenta; several categories of "complications of the administration of anaesthetic or other sedation in labour;" and several categories of "other complications of labour and delivery, not elsewhere classified."

Spontaneous Abortion; Legally Induced Abortion; Other Abortion; Other Pregnancy with Abortive Outcome; Haemorrhage of Pregnancy; and Complications of the Puerperium are the remaining diagnoses associated with pregnancy and the postpartum. Each of these major categories, of course, has numerous sub-categories. The total number of diagnoses in these categories in respective order was: 3,324; 306; 220; 2,465; 1,874; and 658 for a total of 8,757 (Alberta Health, 1993:34).

PROCEDURES (Statistics Canada, 1986:353-362).

Forceps, Vacuum and Breech Delivery includes several categories of "Forceps extraction and other instrumentation."

Other Procedures Inducing or Assisting Delivery includes several sub-categories: several categories of "artificial rupture of the membranes;" several categories of "other surgical induction of labour;" several categories of "internal version and extraction;" several categories of "failed forceps;" several categories of "operations on fetus to facilitate delivery;" several categories of "medical induction of labour" (excluding augmentation of labour); several categories of "manually assisted delivery;" several categories of episiotomy (excluding those performed in association with

forceps or vacuum extraction); several categories of "other operations assisting delivery."

Cesarean Section and Removal of Fetus includes several sub-categories of caesarean section.

Other Obstetric Operations includes several sub-categories: several categories of therapeutic abortion; "amniocentesis;" "intrauterine transfusion;" "other intrauterine operation on fetus and amnion" (including "insertion of scalp electrodes"); "removal of retained placenta," "repair of laceration of uterus;" "repair of other obstetric lacerations;" and "other obstetric operations."

2. From this data it cannot be known the extent to which the medical definition "normal delivery" corresponds to the research participants' various definitions of "normal, healthy, natural" childbirth. In the criteria given for the definition "normal delivery" there is no indication whether such births include or do not include women who were administered pain medication or women who received an episiotomy. Furthermore, the research participants did consider a VBAC (vaginal birth after caesarean) to be "normal" but such a birth is not so defined in the medical criteria.

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APPENDICES

APPENDIX I: Advertisements

NEWSPAPER ADVERTISEMENT

EXPECTING YOUR FIRST BABY?
University of Alberta Masters student seeking pregnant women to participant in a study of prenatal learning about childbirth. If interested please call Laurie at 436-3448.

ADVERTISING FLYER

EXPECTING YOUR FIRST BABY?

Would you consider participating in university research? If so, I would love to talk to you.

I am a Masters student at the University of Alberta, and am conducting research on the various kinds of information women learn about childbirth in the prenatal period.

If you, or someone you know, would be willing to participate in this study or if you would like more information, please call Laurie at 436-3448.

University of Alberta,
Department of Anthropology.

APPENDIX II: Answering Machine Message

Hello. If you have called about the study on what women learn about childbirth, I am hoping to interview pregnant women who are between the ages of 20 and 35 and who have never before given birth to a baby. The interview will take about two hours of your time. If you are interested in participating in this study, please leave your name, telephone number, a time when you can be reached, and the month in which you expect your baby to be born. I will call you back as soon as possible. Thanks for calling.

Answering Machine Message - After Sample Has Been Obtained

Hello. You have reached the study for what women learn about childbirth. I appreciate your interest in this study, but I have already found enough volunteers who have agreed to participate. Thank you for calling.

APPENDIX III: Outline of Study to Potential Participants

In this study I am trying to find out what women learn about childbirth before they give birth for the first time. Are you pregnant right now? Is this your first baby? Do you intend/have you attended prenatal classes?

The study will take up to two hours of your time in one or more interviews. Would you be willing to give that much time to the study? Will you allow me to tape record the interviews?

Would it be alright if I interviewed you in your home, or would you prefer the interview to take place somewhere else? What would be a suitable time for you?

I would like to send you a questionnaire. Would you please fill it out and give it back to me on the day of the interview?

APPENDIX IV: Interview Guide

1. Tell me what you know about what it is like to give birth.
1a. What is it like to give birth?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 2).

Tell me what the room will be like; what will it look like? what will it smell like? what will it sound like? what kind of furnishing will it have?
Tell me who will be there. What will they be doing?
Tell me what it will feel like to give birth?
Tell me what your feelings will be like (emotional/physical).

(Dobbert's Theoretical Model: Deposit of Cultural Knowledge (Section 1.1.4).

2. Tell me how you found out about what it will be like to give birth.
2a. Have you come to the conclusion about what it will be like to give birth by yourself, or did you find out about it from somewhere else?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 3).

Did you ever ask anyone about it? (mother, sister, friend, grandmother)
Did anyone ever tell you about it without you asking?
Will you tell me what they said?
Do you remember when your sibling was born?
Have you ever seen animals give birth?
Did you have sexual education classes when you were in school?
Did you ever read about what it would be like to give birth?
Will you tell me about what you read? What are the names of the books? Where did you get this material?
Did you ever hear about giving birth on the radio, or see it on T.V. or in a movie? Will you tell me about that?

(Dobbert's Theoretical Model: Other Persons/Responding Person (Section 1.2.1); Values Held (Section 1,2,2); Activities (Section 3.1.2); Patterns of Control/Response (Section 3.2).

3. What was it like when you were having this conversation/watching T.V. etc.?
3a. Can you tell me something about the circumstances of that conversation?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 4).

Can you tell me who was there?
When was it? How old were you?
Where was it?
Why did the topic arise?

What did you think about it?

(Dobbert's Theoretical Model: Group Size and Composition (Section 3.13); Named Institutions (Section 3.1.1); Activities (Section 3.1.2); Deposit of Cultural Knowledge (Section 1.1.4).

4. Have you ever heard or read anything about giving birth that confused you, or that you didn't think was true? Will you tell me about that?
4a. Have you heard things about what it is like to give birth that you thought were false? Will you tell me about that?
4c. Have you ever come across any information about birth that is controversial?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 5).

Have you always been sure/unsure about what it would be like to give birth?
Will you tell me about which information has been helpful/unhelpful for you in making up your mind about what it is like to give birth?
What about pain medication? What are the advantages and disadvantages?
What are the advantages and disadvantages of experiencing pain?
Have you heard about induction? What are the advantages and disadvantages? What is the reason for induction?
What about caesarean section? What are the advantages and disadvantages? What is the reason for caesarean section?
What about midwives? What are the advantages and disadvantages of having a midwife?
What about home birth? What are the advantages and disadvantages of giving birth at home?
What are the advantages and disadvantages of giving birth in the hospital?

(Dobbert's Theoretical Model: Values Held (Section 1.2.2); Activities (Section 3.1.2); Deposit of Cultural Knowledge (Section 1.1.4)

5. Where did you learn about this?
5a. Can you tell me something about the circumstances?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 6).

Can you tell me who was there?
When was it?
Where was it?
Why did the topic arise?
What did you think about it?

(Dobbert's Theoretical Model: Group Size and Composition (Section 3.13); Named Institutions (Section 3.1.1); Activities (Section 3.1.2); Deposit of Cultural Knowledge (Section 1.1.4).

6. Have you ever heard or read anything about giving birth that changed your mind about what you thought before? Will you tell me about that?
6a. Have you ever thought something different about what it would be like to give birth? Will you tell me about that?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 7).

What helped you to change your mind?
Who gives you credible/non-credible information?

(Dobbert's Theoretical Model: Other Persons/Responding Person (Section 1.2.1); Values Held (Section 1.2.2); Activities (Section 3.1.2); Deposit of Cultural Knowledge (Section 1.1.4)

7. What was it like when this happened?
7a. Can you tell me something about the circumstances?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 8).

Can you tell me who was there?
When was it?
Where was it?
Why did the topic arise?
What did you think about it?

(Dobbert's Theoretical Model: Group Size and Composition (Section 3.13); Named Institutions (Section 3.1.1); Activities (Section 3.1.2); Deposit of Cultural Knowledge (Section 1.1.4).

8. If you could have things the way you want, how would it go?
8a. How would it be if you could design birth yourself?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 9).

Where would you be?
Who would be there?
What would they be doing?
What would you be doing?
How would you feel?

(Dobbert's Theoretical Model: Deposit of Cultural Knowledge (Section 1.1.4); Values Held (Section 1.2.2).

9. Will you tell me about the prenatal classes you have been to?
9a. What are the prenatal classes like?
9c. Which prenatal classes have you enroled in?

(Don't know, insufficient answer - go to probes)(Full Answer - go to 10).

Can you tell me who is there?
When are they held?
Where are they held?

What do you talk about there?
What did you think about it?
What do you find is helpful/unhelpful? Why?

(See Theoretical Model, Appendix VI: Other Persons/Responding Person (Section 1.2.1); Values Held (1.2.2); Group Size and Composition (Section 3.13); Named Institutions (Section 3.1.1); Activities (Section 3.1.2); Deposit of Cultural Knowledge (Section 1.1.4).

10. What is the most important thing you know about birth?
Where did you learn it?

(See Theoretical Model, Appendix VI: Deposit of Cultural Knowledge (Section 1.1.4).

11. Some women I have interviewed have said... (ex. the main thing they want to learn is about birth itself). Have you ever found that? Will you tell me about it?

(Reliability and validity check).

12. You are aware that when I write about what you have told me I will use a made-up name rather than using your name. Is there a made-up name that you particularly like?

APPENDIX V: Demographic Questionnaire

Name_____Today's Date_____

Address_____

Telephone_____(home)_____(work)

When do you expect to give birth to your baby? _____

Which prenatal classes have you enroled in? _____

Have you ever seen a baby born? _____ _____
yes no

Have you ever seen an animal born? _____ _____
yes no

Where did you grow up?_____ _____ _____ _____ _____
large city small city town rural area on a farm

Your Date of Birth _____ _____ _____
year month day

Number of Siblings _____ _____ _____ _____ _____ _____ _____
0 1 2 3 4 5 other

Sibling rank _____ _____ _____ _____ _____ _____
1st 2nd 3rd 4th 5th other

How much older are you than your younger siblings? _____

Marital Status _____ _____ _____ _____ _____
Single Married Common-Law Divorced Widowed

Persons who live with you _____

_____

Languages Spoken

_____

1st Language Learned as a Child

_____

Born in _____

Have lived in Canada for _____ _____ _____ _____ _____
0-1 years | 2-5 years | 6-10 years | 11-15 years | other

Ethnic Group _____

Education _____ _____ _____ _____ _____
0-8 years | 9-12 years | some college or university | completed college or university | graduate/ post-graduate

Employment status _____

Household Income _____ _____ _____ _____
$0-$10,000 | $11,000-$20,000 | $21,000-$30,000 | $31,000-$40,000

_____ _____ _____ _____
41,000-$50,000 | $51,000-$60,000 | $61,000-$80,000 | over $80,000

* The information contained in this questionnaire will remain strictly confidential. When I write about what you have told me I will use a made-up name rather than using your name. Is there a made-up name that you would prefer?

_____

APPENDIX VI: Consent Form for Interviews

Project Title: The Cultural Transmission of Childbirth Knowledge

Researcher: Laurie McCreary-Burke B.A.
Candidate for Masters of Arts Degree, Department of Anthropology
Faculty of Graduate Studies, University of Alberta
Telephone: 434-3136

Supervisor: Dr. Pamela J. Brink
Faculty of Nursing
University of Alberta
Telephone: 492-6763

The purpose of this study is to find out what you know about childbirth and how and where you learned it. In this study, I will ask you questions about where you find information about giving birth and what you think about that information. I will use the information you give me for this study.

Your participation in this study will involve the following:

* I will interview you one time.
* The interview will be done in person. If I need more information, I will call you and ask you some more questions.
* I will interview you in your home, or you and I will choose another place suitable to both of us.
* The interview will last about two hours.
* I may ask you to read and comment on what I have written.

All interviews will be tape recorded. My thesis committee, my typist and I are the only ones who will listen to your tapes, or read the transcripts of the tapes. I will keep both your tape, and the transcript of your tape in a locked cabinet at my home for a minimum period of seven years.

Your participation in this study is your choice;

* You may refuse to answer any question during an interview.
* You may stop the interview at any point.
* You can withdraw from the study at any time. I will use the information you have given before your withdrawal only with your permission. If you decline permission, I will destroy all interview recordings and transcripts when the study is done.

I may use quotes from the interview in descriptions of the study. Your name or initials will not be used in these descriptions. Rather, I will make up a name for you. I will use this made up name in all descriptions of the study.

You may ask me any questions about the study. I will answer your questions so that you are satisfied with the answers. You may have other questions or concerns about the study. You can telephone me, or you may talk to my supervisor, Dr. Pamela Brink.

If I conduct further research on the collected materials in the future, I will have an appropriate committee review my proposal.

There is a slight risk that someone who listens to your tape may be able to recognize your voice and know who you are. There are no physical risks to you if you participate in this study. You may not benefit from this study. However, you may find it helpful talking to the researcher about what you think childbirth will be like. By participating in this study, you may help other people who wonder what childbirth will be like. I am required by law to report instances of abuse, but I will not do so until I have discussed the matter with you.

I, _____, agree to participate as a
(Print name)
volunteer in this study.

I have a copy of this form to keep.

_____ _____
(Participant's Signature) (Date)

_____
(Researcher's Signature)